

Change Request Form

PacifiCare®
Life and Health Insurance Company
P.O. Box 6098
Cypress, CA 90630
(Address for PPO/Indemnity Enrollees)

PacifiCare®
of California
5701 Katella Avenue
Cypress, CA 90630
Attn: Membership Acctg.

IMPORTANT: PLEASE PRINT OR TYPE ALL SECTIONS IN BLACK INK

PacifiCare ID Number (If Applicable)		Employer Name		Group Number (If Applicable)	
Last Name		First	MI		Social Security Number
Address		Apt No.	City	State	Zip Code
Home Telephone () ()			Work Telephone () ()		Extension

CHANGE OF PERSONAL INFORMATION

- Change my address/phone as indicated above.
- Change my name as shown above. My former name was _____

CHANGE OF DEPENDENT STATUS

Newborn, adoption, marriage, open enrollment, other (for "other" please attach a letter of explanation)

Add or Delete	Relationship	Last Name	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	Sex M or F	First Name	MI	PCP or Medical Group Number
Add or Delete	Relationship	Last Name	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	Sex M or F	First Name	MI	PCP or Medical Group Number

CHANGE OF OTHER INSURANCE CARRIER INFORMATION

Add or Delete	Last Name	Social Security Number	Health Coverage Name	Other Employee Name and Address
	First Name	MI	Date of Birth (Month - Day - Year)	
Add or Delete	Last Name	Social Security Number	Health Coverage Name	Other Employee Name and Address
	First Name	MI	Date of Birth (Month - Day - Year)	

CHANGE OF PLAN TYPE Plan changes can only be made during open enrollment. Before you change your plan, please confirm that your employer offers these plans. All family members must be in the same plan.

From: To:

- HMO** _____
- POS** _____
- PPO*** _____
- Indemnity*** _____

* Underwritten by PacifiCare Life & Health Insurance Company.

CHANGE OF PCP/MEDICAL GROUP (HMO/POS Only) If you would like to change your PCP or Medical Group**, you may do so once a month. The fastest and easiest way to do this is to call our Customer Service Department. HMO members call 1-800-624-8822, POS members call 1-800-913-9133. If you would prefer to do this in writing, please complete the section below.

Complete this "PCP Selection" section if you are changing your plan type to an HMO or POS plan from a PPO or Indemnity plan, or if you are currently enrolled in an HMO or POS plan and want to change your current PCP.

- Please select a doctor near your home for you and each of your family members from your PacifiCare Provider Directory and write the name and number below.
- Please indicate your first and second choice.
- You may choose a different doctor for each member of your family.
- Did you select a doctor? If not, we will select one for you.

NOTE: Over age dependents require proof of full time student status or permanent disability within 31 days of enrollment. Form cannot be processed if information is incomplete.

PCP SELECTION (HMO/POS Only)

1	Self	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	
2	Spouse	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	
3	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	
4	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	

Your Signature _____ Date _____

Employer Verification / Authorized Signature _____ Ph. # _____ Date _____

For help call our Customer Service Department at 1-800-624-8822 (HMO), 1-800-913-9133 (POS) or 1-866-316-9776 (PPO/Indemnity).

PACIFICARE USE ONLY

PAC EFFECTIVE DATE	VERIFIED BY	DATE VERIFIED

**All medical group changes must be approved by PacifiCare before becoming effective. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Please have your condition evaluated by your new primary care physician.