

MEDICAL ASSISTANCE MANAGED CARE PROVIDER SELECTION FORM

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Select a Primary Care Provider from the list of available providers. Providers with an “*” next to their names indicate that they have full caseloads and are not accepting new patients. Only recipients who are current patients may select a provider who has a full caseload.

Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, and Medical Residents may be listed on the provider list but are not primary care providers. To access medical care from these providers, select the primary care provider they are listed under.

NOTE: All Managed Care eligible family members do not have to choose the same Primary Care Provider.

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- I understand that I **MUST** choose one Primary Care Provider for each eligible managed care family member by completing the section below **AND** returning the completed form to the Department of Social Services.
- If I do not choose a Primary Care Provider, the State Office of Medical Services will choose a Primary Care Provider for me and all other managed care eligible family members.
- I understand that I may request to change my Primary Care Provider at any time.

	MANAGED CARE RECIPIENT'S NAME <small>(Family members eligible for Medical Assistance)</small>	RECIPIENT ID NUMBER <small>(from notice or ID card)</small>	PRIMARY CARE PROVIDER NAME <small>(from Provider list)</small>	PCP CODE <small>(from Provider list)</small>
0				
1				
2				
3				
4				
5				
6				
7				
8				
9				

I understand the Medical Assistance Managed Care Program rules and requirements and also understand that by not following those rules and requirements I may be responsible for payment of medical bills. Refer to the *Medical Assistance Program Recipient Handbook* for more information.

Your Name _____

Telephone Number _____

Date _____