BADGERCARE PLUS
NOTIFICATION OF CHANGE - PRIMARY CARE PROVIDER PCP)

Please list below all family members who wish to change their Primary Care Provider to the Provider listed below.

Effective date will be the date the Member signs and authorizes the change.

Provider Name *(first and last)*: ______________________________

Provider Phone Number: ______________________________

Office Address: ______________________________

Submitting Office Fax #: ______________________________

Member Information

☐ **Yes, change member to provider listed *(check box).*** First Name: ______________________________

Last Name: ______________________________

Medicaid ID #: ______________________________

Street Address: ______________________________

City: ____________________ State: __________ Zip: ______________

Current Telephone #: ______________________________

**************Member Signature:*** ______________________________ ***Date:*** ______________

(I authorize the listed PCP changes.)

Child / Children Information

☐ **Yes, change child to provider listed *(check box).*** **Child # 1:**

Name *(first and last)*: ______________________________

Medicaid ID #: ______________________________

☐ **Yes, change child to provider listed *(check box).*** **Child # 2:**

Name *(first and last)*: ______________________________

Medicaid ID #: ______________________________

☐ **Yes, change child to provider listed *(check box).*** **Child # 3:**

Name *(first and last)*: ______________________________

Medicaid ID #: ______________________________

Please fax this completed form to My Choice Wisconsin Health Plan at 414-755-4410

To be completed by Provider Name, Address, Phone # (or stamp)

If you have any questions call Customer Service at **855-530-6790**
Please retain a copy for the Member(s) file.

DHS Approved: 4/7/2021