Prominence℠ Health Plan

PCP REQUEST FOR MEMBER TRANSFER

Medical Records #

Physician:	Member:
ID#:	ID#:
Telephone:	Telephone:
Fax:	

Please include detailed reason for request:		
☐ Disruptive behavior	☐ Non Compliance with treatment	
Missed Appointment: Date:	Date:	Date:
Other:		
Description:		

PLEASE SUBMIT A COPY OF THE PROGRESS NOTES FROM THE MEMBER'S MEDICAL RECORD THAT DOCUMENTS YOUR CONCERN.

Physician Signature:	Date:

Instructions:

Please complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Do not discuss your request to transfer a member from your care until you receive approval from Prominence Health Plan.

Submit your request to:

Prominence Health Plan
PO Box 15859
Tampa, FL 33684-5859

-or-

You may fax back the completed form and documentation to 775-770-9366.

Section to be completed by the Health Plan		
Medical Director: Approved or Disapproved Signature:		
Date Received:	Date Closed:	New PCP Assignment: Yes or No Effective Date: