



Primary Care Physician Change Request Form

(To be completed and submitted by the physician with the patient's consent)

(Please print clearly and complete ALL fields.)

Your primary care physician is the doctor you go to first and most often for your health care needs and for guidance about important preventive care to keep you healthy and active. By signing this form, you are selecting a new primary care physician and notifying Humana to make this change to its files.

Option for member to self-select primary care physician by phone

You also can select a different doctor as your primary care physician by calling Humana at the number found on the back of your ID card.

Option for member to select primary care physician in physician's office

Patient name: _____ Date of birth: _____

Humana member ID: _____ Phone number: _____

Patient signature: _____ Date: _____

Current primary care physician	
Name: _____	Group/location: _____
New primary care physician	
Full name: _____	Group/location: _____
Tax ID: _____	Address: _____
Effective date of change: _____	Vendor/center number (if known): _____
Reason for change: _____	

Preparer name: _____ Date: _____

Preparer signature: _____ Phone number: _____

Submit the form

Please submit the completed form to Humana by fax at **1-800-633-8188** or by mail to Humana, P.O. Box 14168, Lexington, KY 40512-4168.

NOTE: All change requests are subject to verification and physician availability.

