



Request to Change Primary Care Provider

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name.

Additional Family Molina Members

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name.

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name.

Member's Address: _____
(Please print.)

City: _____ State: _____ ZIP: _____

Member's Phone: (_____) _____ Cell or Alt. #: (_____) _____

My Molina ID card currently has my Primary Care Provider listed as: _____
Please print provider's name.

I would like to change my Primary Care Provider to: _____
Please print NEW provider's name.

NEW Provider's Address: _____
(Please print.)

City: _____ State: _____ ZIP: _____

NEW Provider's Phone: (_____) _____

Signature of Member or Delegated Guradian

Relationship

Print FIRST and Last Name

Date

Fax completed form to: (888) 295-4761

Or mail to: Molina Healthcare of Ohio, Inc.
Member Services Department
P.O. Box 349020
Columbus, OH 43234-9020

If you have any questions, please call toll-free:
Member Services: 1-800-642-4168
Hearing Impaired/TTY: 1-800-750-0750 or 711