WELLHEALTH Quality Care
A MedSource Health Care Company

TEACHERS HEALTH TRUST
For Teachers By Teachers

Provider Change Request Form

Member Information

Name _____

Member ID # _____

Phone Number _____

Email _____

Current Provider _____

Desired Provider _____

Practice Name _____

Reason for Change (Please Select One):

☐ I was auto-assigned a provider that I did not choose.

☐ My provider is no longer in network.

☐ My provider has closed their panel and/or is no longer accepting THT patients.

☐ My provider cannot see me within a reasonable time frame.

☐ I do not like the provider I selected (Must provide complaint below).

☐ Other (Please Specify Below).

Please complete and email this form to advocates@wellhealthqc.com

Internal Use Only

Date Received _____ Completed By _____ Date _____