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 WH_Advocates@hcpnv.com

Internal Use Only

Date Received ____________ Completed By ________________________ Date ____________