



Member Data Change Form

For Member Contact Information and PCP Change Requests

Part 1: Member Information

Please provide the member's information.

** = Required Field

(Last Name)*		(First Name)*		(Middle Initial)	
(Member Medicaid ID Number)*			(Member Birth Date)*		
(Current Street Address)*		(City)*		(Zip Code)*	
(Home Phone)*		(Other Phone)			

Part 2: PCP Change Request

Please provide PCP information (only complete if member would like to change PCPs).

** = Required Field

(Requested PCP Full Name)*		(PCP Provider ID)*	
(Office Address)		(City)	
		(Zip Code)	
(Office Phone)			

Reason for Change From Assigned PCP

<input type="checkbox"/> Already a patient with requested PCP	<input type="checkbox"/> Office wait time too long for assigned PCP
<input type="checkbox"/> Requested PCP already sees family member	<input type="checkbox"/> Appointment wait time too long for assigned PCP
<input type="checkbox"/> Assigned PCP is too far	<input type="checkbox"/> Assigned PCP does not accept age
<input type="checkbox"/> Other: _____	

(Signature of Member or Responsible Party)

(Date)

(Print Name of Responsible Party if Different from Member)

Biological parent? Yes No → If "NO," the name of the "Responsible Party" must match exactly what WellCare has on file for "Responsible Party" or change cannot be processed.

Directions: Please fax Member Data Change Form, with a copy of the member ID card¹ if available, to WellCare Customer Service at 1-877-297-3112. If you have questions about how to complete this form, please call WellCare Customer Service at 1-866-231-1821.

¹Note: We require a copy of the member ID card with this form when requesting a PCP change. PCP change requests received by the 10th of the month will be effective THAT month. PCP change requests received AFTER the 10th of the month will be effective the FOLLOWING month.