Member PCP transfer request form

Complete this form with 60 calendar days notice to request a patient transfer to an alternate PCP. **For MassHealth members,** you must **also** complete the Involuntary Disenrollment Form to request a PCP transfer.

Date: _____

PCP information	
PCP name	Group name
Address (City, State, Zip code)	
Phone	Contact name
Remit address (City, State, Zip code)	
Remit phone	Remit fax

Member information	
Name (last, first, middle initial)	
WellSense member ID #	Date of birth (mm/dd/yyyy)
Parent/guardian name	
Address (City, State, Zip code)	
Phone	

Additional information

Please include additional information that would help with WellSense Health Plan's outreach efforts:

Reason for member transfer

☐ Multiple no-shows	☐ Member relocated
Dates of no-show appointments and department (mm/dd/yyyy)	
Dates of appointments kept and department (mm/dd/yyyy)	
☐ Unsuccessful contact with member	☐ Non-compliant with medical treatment
☐ Behavioral concerns	☐ Verbal/physical abuse or altercation

Please specify:

Medical issues

☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Pregnancy	☐ Substance Use Disorder

Other (Please specify)

Please provide documentation of appointments, and dates and types of outreach activities conducted by the provider. WellSense Health Plan will outreach to the member to determine the reason for missed appointments or non-compliance, and will provide a transition plan to ensure there is no interruption in care or services.

Fax the completed form to WellSense Health Plan's Enrollment department at 617-897-0844 (for Massachusetts members) or 866-779-5948 (for New Hampshire members).