ATTACHMENT 2

SPECIALIST AS A PCP REQUEST FORM
Children with Special Health Care Needs (CSHCN) Identification Form

Date of Request:	**Received in Member Services**
Member Name:	**Member ID Number:**
Member Address:	**Member Phone Number:**
PCP on Record	**Specialist Requesting PCP Status**
Member Diagnosis	
Clinical Data	

I hereby request to serve as a Primary Care Physician for the above named member with special healthcare needs. I am willing to accept responsibility for the coordination of all of the members health care needs as well as abide by any and all contractual obligations.	
Specialist Signature	
Member's Reason for Request	
Member Signature	
Approved ☐ YES ☐ NO	**Effective Date:** ***Note the effective date will not be retroactive"**
Medical Director Signature: **Date:**	
Date Sent to Provider Relations	**Date Sent to Member Services**
Provider Relations Director Signature	**Member Services Director Signature (Confirming PCP change)**