



CALIFORNIA

Change Request Form

CHANGE REQUEST FORM

Important: Please print or type all sections in black ink

Current Personal Information				
PacifiCare ID # (if applicable)		Employer Name		Group # (if applicable)
Last Name		First Name		MI
Address		Apt #	City	State
Home Telephone ()		Work Telephone ()		Extension

Change of Personal Information	
<input type="checkbox"/>	Change my address/phone as indicated above.
<input type="checkbox"/>	Change my name as shown above. My former name was _____

Change of Dependent Status				
Newborn, adoption, marriage, open enrollment, other				
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Relationship	Last Name	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	<input type="checkbox"/> Female <input type="checkbox"/> Male	First Name	MI	PCP or Medical Group Number
				Reason <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other*
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Relationship	Last Name	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	<input type="checkbox"/> Female <input type="checkbox"/> Male	First Name	MI	PCP or Medical Group Number
				Reason <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other*

* For "Other," please attach a letter of explanation.

Change of Other Insurance Carrier Information				
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name	Social Security Number	Health Coverage Name	Other Employer Name and Address
	First Name	MI	Date of Birth (Month - Day - Year)	
			Policy No./Effective Date	
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name	Social Security Number	Health Coverage Name	Other Employer Name and Address
	First Name	MI	Date of Birth (Month - Day - Year)	
			Policy No./Effective Date	

Change of Plan Type	
Plan changes can only be made during open enrollment. Before you change your plan, please confirm that your employer offers these plans. All family members must be in the same plan.	From (check one)
	<input type="checkbox"/> PacifiCare SignatureValue SM (HMO)
	<input type="checkbox"/> PacifiCare SignaturePOS SM
	<input type="checkbox"/> PacifiCare SignatureOptions SM (PPO)*
	<input type="checkbox"/> PacifiCare SignatureIndependence SM (Indemnity)*
	<input type="checkbox"/> PacifiCare SignatureFreedom SM (SDHP)*
To (check one)	
<input type="checkbox"/> PacifiCare SignatureValue SM (HMO)	
<input type="checkbox"/> PacifiCare SignaturePOS SM	
<input type="checkbox"/> PacifiCare SignatureOptions SM (PPO)*	
<input type="checkbox"/> PacifiCare SignatureIndependence SM (Indemnity)*	
<input type="checkbox"/> PacifiCare SignatureFreedom SM (SDHP)*	

If you are changing your plan type from a PPO or Indemnity plan to an HMO or POS plan, complete the "Change of Primary Care Physician" section on the reverse of this form.

Signature required on the following page

Employee Name	Social Security #	Group # (if applicable)
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Change of Primary Care Physician (PCP)/Medical Group (HMO/POS Only)**

If your change request is received by PacifiCare by the 15th of the month, the change will be effective the first of the following month; if your request is received by PacifiCare after the 15th of the month, the change will be effective the first day of the subsequent month. For Example: If your PCP change request is received January 14, the change is effective February 1. If your request is received January 20, the change is effective March 1. Some restrictions apply. Please ask your employer or call PacifiCare's Customer Service department.

PCP Selection (HMO/POS Only)

Complete this "PCP Selection" section if you are changing your plan type to an HMO or POS plan from a PPO or Indemnity plan, or if you are currently enrolled in an HMO or POS plan and want to change your current PCP.

- You may choose a different doctor for each member of your family.
- Did you select a doctor? If not, we will select one for you.
- Newborns remain enrolled with the mother's PCP from birth until discharged from the hospital. Please refer to your *Combined Evidence of Coverage and Disclosure Form* for further details.

- Please select a doctor near your home for you and each of your family members from your PacifiCare *Provider Directory* and write the name and number below.
- Please indicate your first and second choice.

Note: Over age dependents require proof of full-time student status or permanent disability within 31 days of enrollment. Form cannot be processed if information is incomplete.

1	Self	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Female <input type="checkbox"/> Male	First Name MI	Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	
2	Spouse	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Female <input type="checkbox"/> Male	First Name MI	Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	
3	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Female <input type="checkbox"/> Male	First Name MI	Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	
4	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Female <input type="checkbox"/> Male	First Name MI	Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	

**All medical group changes must be approved by PacifiCare before becoming effective. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Please have your condition evaluated by your new primary care physician.

Signature – Required for all changes

Your Signature	Date
Employer Verification/Authorized Signature	Phone # ()
	Date

PacifiCare Use Only

PAC Effective Date	Verified By	Date Verified
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**PacifiCare SignatureValueSM (HMO)
and PacifiCare SignaturePOSSM (POS)**

5701 Katella Avenue

Cypress, CA 90630

Attn: Membership Accounting

800-624-8822 – HMO

800-913-9133 – POS

**PacifiCare SignatureOptionsSM (PPO),
PacifiCare SignatureIndependenceSM (Indemnity)
and PacifiCare SignatureFreedomSM (SDHP)**

P.O. Box 6098

Cypress, CA 90630

866-316-9776 – PPO/Indemnity

866-867-0700 – SDHP

Visit our Web site @ www.pacificare.com