How to complete SFHP's PCP Change Request form Successfully

San Francisco Health Plan℠

Not intended for consumer use. For informational purposes only.

Section 1

- Please use this tool when you are filling out Section 1.
- When you click on the PCP's name, you'll get additional information necessary for Section 1, such as the NPI and fax number.
  - The PCP Change Form cannot be processed without the Provider's NPI #

Primary Care Provider (PCP) Change Request Form

Please complete this form to request assignment to a new Primary Care Provider.

Send completed forms via Secure Email: PCPChangeRequest@sfhp.org

San Francisco Health Plan

Section 1: About the Primary Care Provider (PCP) - enter information for the new PCP being requested

PCP Name (First, Last) | PCP NPI#

Clinic or Practice Name

Clinic or Practice Street Address

City | State | Zip Code

Phone with Area Code | Fax with Area Code

Section 2: About the Member/Patient

Member/Patient Name (First, Last)

SFHP ID # (from SFHP ID Card) | Date of Birth

Phone with Area Code | Email Address

Home or Street Address

City | State | Zip Code

Note: the new SFHP ID Card with the requested PCP will be sent to the Member/Patient at the address provided above.

Section 3: Please give a reason for this PCP change request

- ☐ This PCP location is more convenient or accessible to the Member/Patient
- ☐ This PCP is a better fit for the personal needs or preferences of the Member/Patient
- ☐ This PCP treats other individuals in the Member/Patient household (e.g., child, spouse, or parent)
- ☐ A different reason – please describe:

Section 4: Please select Yes or No for all of the following questions - the PCP change request cannot be processed without this information

Has the Member/Patient had an appointment with another PCP in the current month?	☐ Yes	☐ No
Has the Member/Patient seen a Specialist or other Doctor in the current month?	☐ Yes	☐ No
Has the Member/Patient been admitted to the Emergency Room in the current month?	☐ Yes	☐ No
Has the Member/Patient been Hospitalized in the current month?	☐ Yes	☐ No
Has the Member/Patient received Lab Services in the current month?	☐ Yes	☐ No
Does the Member/Patient need any Pharmacy or Medication refills?	☐ Yes	☐ No

Section 5: Please indicate who is making this request for PCP change - the PCP change request cannot be processed without this information

- ☐ The Member/Patient (self) or Parent/Legal Guardian if minor
- ☐ A Representative of the Member/Patient

Representative Name | Relationship to Member/Patient

00926 1225

Section 2

- Please complete this section with all of the member's information.
  - The PCP Change Form cannot be processed without the Member's SFHP ID #
- If the member does not have an address to provide, please use the General Delivery address 391 Ellis St, San Francisco, CA 94102.

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☐ A different reason – please describe:

Section 4: Please select Yes or No for all of the following questions -
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Has the Member/Patient had an appointment with another PCP in the current month? ☐ Yes ☐ No

Has the Member/Patient seen a Specialist or other Doctor in the current month? ☐ Yes ☐ No

Has the Member/Patient been admitted to the Emergency Room in the current month? ☐ Yes ☐ No

Has the Member/Patient been Hospitalized in the current month? ☐ Yes ☐ No

Has the Member/Patient received Lab Services in the current month? ☐ Yes ☐ No

Does the Member/Patient need any Pharmacy or Medication refills? ☐ Yes ☐ No

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Section 3

- The member can provide any reason for requesting a PCP change.
- If the member is changing PCP because of a grievance, please file an online grievance with the member on the SFHP website or call SFHP Customer Service to file a grievance via phone at415-547-7800.

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Does the Member/Patient need any Pharmacy or Medication refills?	☐ Yes	☐ No

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Section 4

- If the member responds yes to any of these questions, the PCP change will be effective the first of the following month.
- If the member responds no to any of these questions, the PCP change can be processed as “retroactive”, effective the first of the current month.

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Does the Member/Patient need any Pharmacy or Medication refills?	☐ Yes	☐ No

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Section 5

- Please complete and sign the form.
- Send the completed form to PCPChangeRequest@sfhp.org
- Processing time will be up to 3 business days.
- **For any urgent or escalated situations please call SFHP Customer Service team at 415-547-7800.**
  - **For example: Member has an appointment this week or member has a procedure scheduled this week.**

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Unsuccessful Criteria

- Not being able to provide the NPI in Section 1.
- Not being able to provide the SFHP ID in Section 2.
- Not signing Section 5.

Questions?

- Send any questions to PCPChangeRequest@sfhp.org
  - Please include contact information if you would like a call back request.
  - Name, Phone Number, and Member ID.
  - Any questions or concerns, aside from PCP change forms, should be directed to Provider relations at extension 7084.