univera HEALTHCARE

Primary Care Provider Selection Form Rev. 1.18

This form is to be completed for Essential Plan, Senior Choice – POS, Senior Choice – HMO, Univera Healthcare MyHealth℠, Univera Healthcare MyHealth Plus℠, Univera Healthcare Child Health Plus Members Only.

Once completed, please fax this form to 1-844-299-1581.

Member Name (first, middle, last):_____

Subscriber ID Number: _____Member DOB: ____/____/_____

Primary Care Physician Name: _____Effective Date: ____/____/_____

Primary Care Physician NPI Number: _____

Primary Care Physician Office Address: _____

_____

Member's or Legal Guardian's Name (first, middle, last):_____

Member's or Legal Guardian's Signature: _____Date: _____/_____/_____

Note: If a Nurse Practitioner who is not credentialed with us is requested, the sponsoring PCP, if participating, will be listed instead.

☐Check the box if claim(s) denied due to no PCP selection:

List Claim Number (s):_____

Date(s) of Service:_____

For questions, please contact Customer Care at 1-866-265-5983.