

**State Of Oklahoma
Oklahoma Health Care Authority**

Attention SoonerCare Helpline: Fax: (405) 782-8780

Provider Representative's Name: _____ **Urgent Request: Yes** ___ **NB** ___ **OB: Yes** ___

<p>SoonerCare Provider Change Request Action Form</p>
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Please use this form when requesting a change in your/your family's SoonerCare primary care provider. Members age 14 and over may choose general practice, family practice or internal medicine providers. For children under age 14 you may choose pediatricians, family medicine or general practice providers. You may change your provider up to four times per year.

1. Complete the form below. Be sure to include all information requested including your Medicaid ID number. Incomplete forms may result in your change being delayed.
2. The member must sign this form. Your provider can not sign this form for you.
3. Return the completed form to your health care provider. They will fax the form to SoonerCare for you.

Enrollment changes may take up to 45 days. If you have questions about your PCP change, please contact the SoonerCare Helpline at 1-800-987-7767
Providers: Please make sure your name and provider number is on the form and correct. Fax this form to SoonerCare Helpline at 405-782-8780.

Please Print:

Name of family member Changing PCP/CM	SoonerCare ID Number	Birth Date (required) mm/dd/year	Social Security Number	Name of new Provider	Primary Care Provider Number	OB Estimated Date of Delivery

Your address: _____ **Apt.#** _____ **City** _____ **State** _____ **Zip** _____

Member Signature _____ **Phone number or message phone** _____

For Provider Representative Use Only: Date Received _____ Urgent Request _____ Disenrollment Date _____ Check all that apply: Panel hold _____ Age Restriction _____ Supervisor Approval _____
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For Member Services Use Only: Reason not processed _____ Panel hold on: _____ Age Restriction on _____ Date Received _____ Completed By _____ Date Completed _____ Panel hold off: _____ Age Restriction off _____
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SoonerCare Helpline Use Only: Date Received: _____ Completed by: _____ Reason not Processed: _____
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