CareSource
Health Care with Heart

Member Reassignment Form

Provider/Facility:_____ **POC:**_____

Tax ID#:_____ **Phone:** _____

Member Information:

Member name: (required) _____

Member Phone# (required)**:**_____ **Member ID# OR DOB** (required)**:** _____

Other Family Members:

Member name:_____ **Member ID# or DOB:** _____

Member name:_____ **Member ID# or DOB:** _____

Member name:_____ **Member ID# or DOB:** _____

Reason for Change (required)**:**

☐ Improper use(s) of emergency department
☐ Missed appointment(s)
☐ Non-compliance of medication(s) or treatment
☐ No longer appropriate age for practice
☐ No longer suited to specialty of practice
☐ Other, please describe _____

☐ I want to be contacted by a CareSource representative to discuss the change.

The **required** fields must be completed for the change to be processed. Members can continue to be treated by the requesting PCP until the change is complete. All requests will be processed within three to five business days of receipt.

Provider (staff) Signature_____ Date:_____

Fax requests to 937-226-6916.