

KENPAC SSI PRIMARY CARE PROVIDER (PCP) CHANGE FORM

THIS SECTION TO BE COMPLETED BY MEDICAID ONLY:

Recipient Name _____ Recipient Phone _____ SSN _____
Address _____ City, State, Zip _____
Current Provider ID _____ Current Site Code _____ Date _____
New Provider ID _____ New Site Code _____ Quota: Open / Closed
New Provider Address _____ City, State, Zip _____

THIS SECTION TO BE COMPLETED BY RECIPIENT ONLY:

Please mail to:

**Department for Medicaid Services
Care Coordination Branch, 6E-C
275 East Main Street
Frankfort, KY 40621**

I am requesting a provider change for _____ (Recipient Name)

I am requesting this change because: _____

This request will require prior approval from the Department for Medicaid Services (DMS) before a change will be made in your PCP.

Recipient's Signature _____ Date _____

THIS SECTION FOR MEDICAID USE ONLY:

Approved _____ By _____ Date _____

Comments _____

