

**KENPAC PRIMARY CARE PROVIDER (PCP) CHANGE FORM**

**THIS SECTION TO BE COMPLETED BY WORKER ONLY:**

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Case Name \_\_\_\_\_ Case Number \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Worker \_\_\_\_\_ Worker phone \_\_\_\_\_ Client Phone \_\_\_\_\_  
Current Provider ID \_\_\_\_\_ Current Site Code \_\_\_\_\_  
New Provider ID \_\_\_\_\_ New Site Code \_\_\_\_\_ Quota: Open / Closed  
New Provider Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY CLIENT ONLY:**

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*Please complete with your worker, or 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 \_\_\_\_\_ (Client 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. I understand that I have the right to receive fair and impartial treatment from my worker regardless of age, sex, race, religious beliefs, political affiliation, national origin, or disability.

\_\_\_\_\_  
Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS SECTION FOR MEDICAID USE ONLY:**

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Approved \_\_\_\_\_ By \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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