Request to Change Primary Care Provider

Member's Name: _____ Member's Molina ID #: _____

Please print FIRST and LAST name.

Additional Family Molina Members

Member's Name: _____ Member's Molina ID #: _____

Please print FIRST and LAST name.

Member's Name: _____ Member's Molina ID #: _____

Please print FIRST and LAST name.

Member's Address: _____

(Please print.)

City: _____ State: _____ ZIP: _____

Member's Phone: (_____)_____ Cell or Alt. #: (_____)_____

My Molina ID card currently has my Primary Care Provider listed as: _____

Please print provider's name.

I would like to change my Primary Care Provider to: _____

Please print NEW provider's name.

NEW Provider's Address: _____

(Please print.)

City: _____ State: _____ ZIP: _____

NEW Provider's Phone: (_____)_____

_____ _____

Signature of Member or Delegated Guradian *Relationship*

_____ _____

Print FIRST and Last Name *Date*

Fax completed form to: (614) 781-1474

If you have any questions, please call toll-free:
Member Services: 1-800-642-4168
Hearing Impaired/TTY: 1-800-750-0750 or 711

Or mail to: Molina Healthcare of Ohio, Inc.
Member Services Department
P.O. Box 349020
Columbus, OH 43234-9020