Physical Health Plan Change Request Form

Providers should complete this form to request a change to a Member's Physical Health Plan. Please note that *most* plan changes will be effective 3 days after a completed request has been received. For all PCP changes, please contact the member's health plan directly.

Members should not complete this form. If a member would like to change their Physical Health Plan, they should call 503-416-8090.

***Indicates Required Field**

Date Form is Submitted to Health Share*: Date of Service*:

Name of Person Completing Form*:

Phone Number for Person Completing Form*:

Name of Organization Requesting Plan Change*:

Member Information

OHP ID*: **OR** SSN*:

A valid OHP ID or Social Security Number is required to correctly process this form.

Last Name*: First Name*:

Date of Birth*:

Primary Care Provider Information

Primary Care Clinic:

Primary Clinic Address:

Primary Care Provider:

Preferred Physical Health Plan Partner

Please indicate the Member's preferred Physical Health Plan (*select only one):*

CareOregon ☐ Kaiser ☐ Providence ☐ OHSU Health ☐ Legacy Health PacificSource ☐

Please send completed form to Health Share via Secure Fax: 503-459-5749 or Secure Email: rae.exceptions@healthshareoregon.org.

Last Revised: January 2019