Physical Health Plan Change Request Form

Use this form to capture preferences for existing medical relationships only after a member in enrolled in Health Share. For all PCP changes, please contact the health plan directly.

****Required Field**—Please complete all required fields

Date		**Person Completing Form****	
Organization**			

OHP ID**		***OR*** **Social Sec. #****	

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

Date of Birth**		**Gender****	**Female** ☐ **Male** ☐
Last Name**		**First Name****	
Phone Number		**E-Mail**	

Preferred form of contact (check one)

Phone ☐ **E-Mail** ☐ **Regular Mail** ☐

Primary Care Clinic (Name)	
Primary Care Clinic Address (Street, City)	
Primary Care Provider (Name)	
Provider NPI #	

Preferred Health Plan Partner (check one) (if member is unsure, please leave blank)

Health Share/CareOregon	**Health Share/Kaiser**	**Health Share/Providence**	**Health Share/Tuality**
☐	☐	☐	☐

Once the form is complete please fax or e-mail **securely** to Health Share at the contacts listed below:

E-mail: rae.exceptions@healthshareoregon.org **Fax:** 503-459-5749