Anthem BlueCross

Cal MediConnect Plan

Specialist as primary care provider request form

Date:_____

Member name:_____

Member ID:_____

Specialist name:_____

Specialty:_____

Primary care provider (PCP) name, if applicable:

_____

Member diagnosis:_____

_____

_____

Provide the medical justification for having a specialist as this member's PCP:

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, member and health plan medical director that the specialist will function as this member's PCP, including providing access to care 24 hours per day, 7 days a week and provision of all preventive health services, including screenings and immunizations required for this member, as per health plan, USPSTF, ACOG, AAP and other guidelines as applicable.

Specialist signature: _____ Date: _____

Medical Director signature: _____ Date: _____

Member signature: _____ Date: _____

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PF-ACA-0041-14 <Date>
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