

Primary Care Provider Acceptance Form

Please complete this form and submit by mail or fax. All information is required.

Section 1 – Patient Information		
Member Name:		Member/Recipient ID #:
Member Address:		
City:	State:	Zip Code:
Member Phone #:		DOB:
Signature of Patient/ Parent/Guardian:		
Section 2 – Provider Information		
Provider's Site/Name:		
National Provider Identification:		
Please change PCP effective (date):		
Section 3 – Office Manager Information		
Name:		
We accept this member into our panel. Yes [] No []		
Office Phone #:	Office Fax #:	
Signature of Office Manager:	Date:	

If you have any questions, please email our Provider Relations Department at providers@ummshealthplans.com.