Primary Care Provider (PCP) Selection Form for Native American Indian Health Care Centers (NAIHC)

Name of NAIHC: ________________________ Phone Number: _______________

SOUTHERN REGION COUNTIES: Lake, Marin, Mendocino, Napa, Solano, Sonoma and Yolo

Last Name	First Name	Date of Birth			Medi-Cal ID # or Social Security No.
		MO	DAY	YR	
Native American Indian: **No**☐ **Yes**☐					
Assign to PCP office **or** Special Native American Status:		If PCP office, indicate name of Medical Office and Provider#:			

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1. Provide the following information for anyone listed on this form who is pregnant:

   Name: ____Due Date: ____________________________
2. I understand that I have a choice of Primary Care Providers (PCPs) that are contracted with Partnership HealthPlan of California (PHC).
3. I understand that if I do not choose a PCP, PHC will assign one to me.
4. I understand that I can change my PCP and that the change will be effective the first of the month after the change was requested.

To ensure that we have the most current information, please provide current mailing address:

Address: ____ City: ___________________________

Zip Code: _____________________ Phone Number: ____

E-mail Address: ____

How would you like to receive your PHC Member Newsletter? ☐ E-Mail ☐ Regular Mail

PHC is required to report your address and phone number changes to your county's Medi-Cal office. This excludes members receiving SSI benefits.

Signature: ____Date: _________________________

Return to: Partnership HealthPlan of California, 4665 Business Center Drive, Fairfield, CA 94534 or you can fax to **(707) 863-4415**