Anthem BlueCross

Primary Care Provider Modification Request

Type of request:	
☐ Limit membership panel to ages 21 years and older ☐ Limit membership panel to ages 20 years and younger ☐ Removal from Medi-Cal Managed Care (Medi-Cal) with ALL Medi-Cal HMO health plans	☐ Change status to specialist only ☐ Other (please specify): ______________________ ____ ____ ____

Address:	City:
ZIP code:	Independent practice association (IPA)/Partner physicians' group (PPG)/Physician medical group (PMG) name(s):*
Phone:	Fax:
Provider signature:	Date:
Provider first and last name (please print):	Title:
License number:	Effective date of request:
Name and title of individual completing this form if other than the provider above (please print):	

*Important: In order to appropriately process and finalize this request, PCP sites are responsible for also notifying their independent practice associations (IPA).

If applicable, please specify the active primary care provider to which existing members affected by the above request will be transferred. Leave blank if no preference.

Receiving provider first and last name (please print):	Title:
License number:	Effective date of request:
Address:	City:
ZIP code:	IPA/PPG/PMG name(s):
Phone:	Fax:

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CABC-CD-019068-23 April 2023

Additional comments:

Please email the form directly to your assigned Facility Site Review Nurse Reviewer or to the department clerk at FSR@anthem.com. You may also fax the form to the Facility Site Review Department at **866-516-4321**.