dell children's
HEALTH PLAN

Specialist as Primary Care Provider Request Form

Date: _____

Member name: _____

Member ID number: _____

Current PCP name (if applicable): _____

PCP Dell Children's Health Plan ID: _____

Specialist/specialty: _____

Specialist Dell Children's Health Plan ID: _____

Member diagnosis: _____

What is the medical justification for having a specialist serve as a PCP for this member?

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, Dell Children's Health Plan and member that the specialist will function as this member's PCP, including providing the member access to care 24 hours a day, 7 days a week and adhering to the PCP responsibilities as detailed in the *Provider Manual*.

Specialist signature: _____ Date: _____

Medical director signature: _____ Date: _____

Member signature: _____ Date: _____

Administered by Amerigroup
4515 Seton Center Parkway, Suite 301 • Austin, TX 78759