GPW Health Center

Dedicated to Your Health!

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Phone 703.680.7950 Fax 703.680.7953 www.GPWHealthCenter.org

PATIENT REQUEST TO CHANGE PROVIDER FORM

I request that the GPW Health Center (Center) change my Provider. This form can be submitted through the following avenues: to a Patient Advocate at the Front Desk, department Coordinator, via Fax (703-680-7953), via Email (info@gpwhealthcenter.org), via Mail to any Center Facility or over the phone with a Medical Scheduler.

Patient Name: _____ **Date of Birth:** _____

Account #: _____ **Practice:** _____

Current Provider: _____

Reason for Change:

_____

_____

Preferred New Provider (if known): _____

The Center will respond to this request within 30 days after receipt of this request. If the Center changes the Provider as you requested, the patient will be notified by mail with their new Provider listed in the decision letter. If the Center decides to not change your Provider, you will be notified by mail with the reason outlined in the decision letter.

_____ _____

Signature of Patient/Personal Representative **Relationship (e.g., Self, Guardian, Parent if a minor)**

Date Signed: _____

☐ **Form completed electronically by Medical Scheduler via phone interaction.**

Medical Scheduler Name: _____

FOR OFFICE USE ONLY:

Request Reviewed by: _____

Date: _____ **Signed:** _____

Revised (5/19)