
PCP REQUEST FOR TRANSFER OF MEMBER

Med Rec # _____

Physician: _____ Member: _____

ID#: _____ ID#: _____

Telephone: _____ Telephone: _____

Fax: _____ Commercial Medicare Medicaid

Please include detailed reason for request:

 Disruptive behavior Non-compliance with treatment

Missed appointment: Date: _____ Date: _____ Date: _____

Other: _____

Description:

_____**Please submit a copy of the progress notes from the member's medical record that documents your concern.**

Physician signature: _____ Date: _____

Instructions:

Complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Requests to transfer a member from your care should not be discussed with the member until approval is received from the Plan.

Submit request to:**Harmony Health Plan
200 W. Adams, Suite 600
Attn: Medical Director
Chicago, IL 60606
Or fax to Medical Director at: (312) 630-2022**

Section to be completed by the Plan

Medical Director: _____

Date Received: _____ Date Closed: _____ New PCP Assignment: _____