McLaren
HEALTH PLAN

PCP Change Request Form

Fax To: McLaren Health Plan (833) 540-8648

Today's Date:	
New Requested PCP: **(Last Name, First Name)**	
Office Address:	
Office Phone Number:	
Member(s) **Full Name:**	
Member(s) ID Number, Date of Birth and Phone Number:	
Member Signature **(If Minor, Parent or Guardian Signature):**	

Please direct questions to Customer Service at (888) 327-0671.

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MclarenHealthPlan.org