Primary Care Provider Selection Form

RESET FORM

wellsense.org | 877-957-1300

Date:

Complete this form if you are accepting a Well Sense member assigned to another PCP practice. Faxes must be received within 24 hours of the date of service in order for claims to be considered for payment.

Member Information		
NAME	DOB	MEMBER ID#
MAILING ADDRESS		
CITY	STATE	ZIP

Primary Care Provider Information		
PRACTICE NAME	PRACTICE LOCATION	
PRACTICE CONTACT PERSON	PRACTICE TELEPHONE	PRACTICE FAX
NEW PCP NAME	REASON FOR CHANGE	
NAME OF MEMBER/PARENT/LEGAL GUARDIAN (please print)		
SIGNATURE OF MEMBER/PARENT/LEGAL GUARDIAN	DATE	

We are allowing the above patient to be assigned to our practice although our panel/provider status may be closed to new patients with Well Sense Health Plan

PLEASE DO NOT WRITE IN THIS SECTION – For Well Sense Internal Use Only		
COMPLETED BY	PCP EFFECTIVE DATE	ID CARD REQUESTED
COMMENTS		

Fax or email completed request to:

Well Sense Health Plan Enrollment

Department Fax: 866-335-9317

For questions, please call:

Well Sense Provider Services: 877-957-1300