REQUEST FORM: SPECIALIST AS PRIMARY CARE PROVIDER

Purpose: CountyCare members have a right to select and change their primary care provider (PCP). If a member would like to request a specialist as their PCP, they should request that the specialist complete, sign, and submit this form to CountyCare. The member can reach out to their care coordinator if additional assistance is needed. Instructions to submit this form are available on Page 2. Please ensure all fields are complete before submitting this form to CountyCare.

Member Information

Member First and Last Name

Member Date of Birth

Member ID

Member's Current PCP Name

Member's Current PCP Practice Name

Reason for requesting specialist as PCP (select all that apply)

- ☐ The specialist is already serving as the member's PCP
- ☐ The specialist was recommended by the member's current PCP
- ☐ The specialist requested to serve as the member's PCP
- ☐ Other (please specify)

Specialist Information

Provider Name

Provider Specialty

Provider NPI

Provider Taxonomy(ies)

Provider Practice Name:

Provider Office Address:					
City:		**State:**		**Zip**	
Provider Phone		**Provider Fax:**			

Member's history of care with specialist: Please describe the existing relationship between the member and the specialist being requested to serve as their PCP, including time in care and which services provided. Please include clinical rationale and attach supporting documentation, as needed.

By signing this form, I agree to serve as the primary care provider (PCP) for the CountyCare member named on Page 1. As their primary care provider, I acknowledge that I am to fulfill all the requirements of a PCP as described in the CountyCare Provider Manual, which is available at **www.countycare.com/providers/provider-manual**. These requirements include, but are not limited to:

- Act as the member's main point of contact with the healthcare system, providing or coordinating all medical and non-medical covered services to ensure access to appropriateness of care.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Educate members on how best to comply with medical advice when they are sick and what plan resources are available to help them direct their own care and/or develop an Individual Plan of Care.
- Obtain authorizations for selected inpatient and outpatient services as listed on the current Prior Authorization List.
- Communicate with the member and facilitate transition to another PCP, should they no longer be appropriately served by you as their chosen PCP.
- Confirm member eligibility before providing services.
- Have admitting (and delivery, where applicable) privileges at a participating hospital or other inpatient facility or a written referral agreement with a provider who does, one who provides for transfer of medical records and coordination of care between providers.
- Work in partnership with the patient's health plan assigned care coordinator/care manager.
- Practice according to generally accepted minimum standards of care and nationally recognized clinical practice guidelines as documented on CountyCare's website.
- Adhere to the CountyCare Cultural Competence Plan, which can be found at **www.countycare.com**.
- Adhere to Access & Availability requirements, including linguistic and physical accessibility standards, appointment availability and after hour coverage.
- Communicate in a manner that accommodates the member's individual needs.
- Cooperate with CountyCare's quality improvement activities and participate in the CountyCare QI Program.

Specialist Name:			
Specialist Signature		**Date:**	

Instructions: Please submit this form and a copy of the member ID card, if available, to CountyCare Health Plan via fax (312-637-8312) or email (**countycarequalityofcare@cookcountyhhs.org**).

If you have questions about how to complete this form, please call the CountyCare Health Plan Member Services department Monday through Friday, 8:30 a.m.-8 p.m., and Saturday, 9 a.m.-1 p.m., at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Internal CountyCare use only

Decision of CountyCare Chief Medical Officer or delegate: ☐ Approve ☐ Deny

Date of decision: _____

Signature of Chief Medical Officer or delegate: _____

Comments: _____