



HEALTH PLAN OF NEVADA  
A UnitedHealthcare Company

**Primary Care Physician Change Request Form**  
**(To be completed by the Member)**  
*(Please Print Clearly)*

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Member Number:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Current Primary Care Physician**

Name: \_\_\_\_\_ Group/Location: \_\_\_\_\_

**New Primary Care Physician**

Name: \_\_\_\_\_ Group/Location: \_\_\_\_\_

Effective Date of New Primary Care Physician: \_\_\_\_\_

Reason for Change: \_\_\_\_\_

**Staff Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(Please Print)*

**Staff Signature:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

*Please submit copy to Health Plan of Nevada at:*

**Health Plan of Nevada, Inc.**

**Attn: Member Services Correspondence**

**Or**

**Fax: (702) 240-6281**

**2720 N. Tenaya Way**

**Las Vegas, NV 89128**

***All change requests are subject to verification and provider availability.***