Do you have a Primary Care Provider (PCP)?

Use this form to select or change a family member's PCP.

Section 1 Patient information

Last name		First name	M.I.
Date of birth (mm/dd/yyyy)	Medicaid ID	PCP name	Established patient? ☐ Yes ☐ No

Section 2 EOCCO family member information

Last name		First name	M.I.
Date of birth (mm/dd/yyyy)	Medicaid ID	PCP name	Established patient? ☐ Yes ☐ No

Last name		First name	M.I.
Date of birth (mm/dd/yyyy)	Medicaid ID	PCP name	Established patient? ☐ Yes ☐ No

Last name		First name	M.I.
Date of birth (mm/dd/yyyy)	Medicaid ID	PCP name	Established patient? ☐ Yes ☐ No

Last name		First name	M.I.
Date of birth (mm/dd/yyyy)	Medicaid ID	PCP name	Established patient? ☐ Yes ☐ No

Last name		First name	M.I.
Date of birth (mm/dd/yyyy)	Medicaid ID	PCP name	Established patient? ☐ Yes ☐ No

Section 3 Authorization

Signature	Date
Relationship to member	Phone

Ready to submit? Fax this form to EOCCO: 503-243-3959

eocco.com

61661653 (1/20)