SCOTT & WHITE HEALTH PLAN

Attachment A

Request for Non-Primary Care Physician Specialist
To Function as Primary Care Practitioner (PCP)

Member's Name: _____ MRN: _____

PCP: _____ Clinic Location: _____

Specialist's Name: _____ Physician No.: _____

Specialty: _____ Phone No.: _____

Member's Diagnosis: _____

Description of the medical need that warrants requesting a non-primary care physician specialist to function as a PCP:

_____

_____

Non-Primary Care Physician Specialist's signature*: _____

Date: _____

*Indicates certification of the need as described above and willingness to accept responsibility for the coordination of all the Member's health care needs.

This section NOT required for SeniorCare Members

I understand that with this change I will need to see the Specialist named above for all of my health care needs. I also understand that since he/she is a specialist, I will pay the Specialist co-pay (if applicable) when treated by him/her on an outpatient basis.

Member's signature: _____ Date: _____

After required signature(s) above are obtained, please send to Medical Director, Scott & White Health Plan @ 2401 S. 31st Street Temple, Texas 76508.

Request Disposition: _____ Approved _____ Denied

Medical Director's signature: _____

Distribution after form completed:

1st copy - PCP 2nd copy - Specialist