

Change Form



PO Box 205 • Grand Rapids, MI 49501-0205

(Member changes must be received by Priority Health within 31 days of the event.)

SECTION 1 - EMPLOYEE INFORMATION			
Employee's Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _

SECTION 2 - CHANGES (Please complete only those changes which apply.)			
<input type="checkbox"/> ADDRESS/PHONE CHANGE	Street Address	City	
State	Zip Code	Home Phone () -	Work Phone () -

<input type="checkbox"/> NAME CHANGE	New Last Name	Former Last Name
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<input type="checkbox"/> DEPENDENT CHANGE (If you have more than 4 dependent changes please complete an additional change form).	Date Change Occurred	Reason for Change Add <input type="checkbox"/> Delete <input type="checkbox"/>		
1	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	
2	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	
3	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	
4	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	

If you, or your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name	Company Address
POLICYHOLDER INFORMATION	Name of Policyholder	Birthdate / /
	Family Member(s) Covered (1) (2) (3) (4)	Policy Effective Date / /
REASON FOR MEDICARE	End Stage Renal Disease <input type="checkbox"/>	Disabled <input type="checkbox"/>
	Over Age 65 <input type="checkbox"/>	Over Age 65 and Working <input type="checkbox"/>
		Effective Date / /

SECTION 3 - AUTHORIZATION			
<p>I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.</p> <p>Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.</p>			
X	Employee Signature	Date	

Employer Name	Group Number	Sub Group Number	Class
Employer/Representative Signature			Date / /
Plan Change <input type="checkbox"/> (If checked, please also check one of the following) HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> HBC <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/>			
Plan Option (if applicable) High <input type="checkbox"/> Mid <input type="checkbox"/> Low <input type="checkbox"/>			
REASONS FOR ADDITIONS			Effective Date / /
Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Loss of other coverage (Proof Required) <input type="checkbox"/> Other _____			
REASONS FOR DELETIONS			Date Coverage Ended / /
Marriage of Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Other <input type="checkbox"/> _____			
REASON FOR TERMINATION OF ENTIRE CONTRACT		Date Occurred / /	Date Coverage Ended / /
Terminated Employment <input type="checkbox"/> Lay Off <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Changed Health Plans <input type="checkbox"/> Moved out of area <input type="checkbox"/>			
Death <input type="checkbox"/> COBRA Terminated <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Other <input type="checkbox"/> _____			

For Priority Health Use Only	Date Received / /	Processor	Code	Date Processed
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