Primary Care Provider Selection Form

WellSense HEALTH PLAN

RESET

Date:

Complete this form if you are accepting a WellSense member assigned to another PCP practice. Faxes must be received within 24 hours of the date of service in order for claims to be considered for payment.

Member Information		
Name	DOB	Member ID#
Mailing address		
City	State	Zip code

Primary Care Provider Information		
Practice name	Practice location	
Practice Contact Person	Practice telephone	Practice fax
New PCP name	Reason for change	
Name of member/parent/legal guardian (please print)		
Signature of member/parent/legal guardian	Date	

We are allowing the above patient to be assigned to our practice although our panel/provider status may be closed to new patients with WellSense Health Plan

PLEASE DO NOT WRITE IN THIS SECTION – For WellSense Internal Use Only		
Completed by	PCP effective date	ID card requested
Comments		

Fax or email completed request to:

WellSense Health Plan Enrollment Department

Fax: 866-335-9317

For questions, please call:

WellSense Provider Services: 877-957-1300

Origination Date: November 2013
Updated 12/2022