GBHC / PeachCare PROVIDER SELECTION FORM

(please print)

Dear Patient:

We are interested in continuing to serve our patients and have agreed to open our practice to serve a specific number of Medicaid and PeachCare for Kids members under the ***Georgia Better Health Care*** program. If you are interested in joining or remaining in our practice, please complete this form.

If you have any questions or concerns, please feel free to call our office at ____________________________ and speak with _____________________________________ or you may call ***Georgia Better Health Care Member Services*** toll free at 1-866-211-0950 or (770) 570-3373 or ***PeachCare Member Services*** toll free at 1-877-427-3224.

____

(Provider name, title - PRINTED)

____

(Provider Address) Street City State Zip Code

(Patient retains top portion)

= =

(Provider)

Yes, ____ would like to serve as a ***GBHC / PeachCare***

(Provider name, title - PRINTED)

primary care provider for the ***GBHC / PeachCare*** member(s) listed below:

_______________________________________ ____

(GBHC Provider number) (GBHC Provider Signature)

Patient information:

_______________________________________ _______________________ _______________________

(Name – PRINTED) (Member Identification) (Phone number)

_______________________________________ _______________________

(Name - PRINTED) (Member Identification)

_______________________________________ _______________________

(Name - PRINTED) (Member Identification)

_______________________________________ _______________________

(Name - PRINTED) (Member Identification)

_______________________________________ _______________________

(Patient or Guardian signature) (Date)

Requests for PCP change received by the 22nd of the month will be effective the first of the following month. Please complete this form and mail or fax it to:

Georgia Health Partnership
P.O. Box 3000
McRae, GA 31055
(866) 483-1044 or (866) 483-1045 - fax

FORMULARIO DE SELECCIÓN DE PROVEEDOR MÉDICO DE ***GBHC / PeachCare***

(port favor, escriba en letra de imprenta)

Estimado paciente:

Nos interesa continuar siriviendo a nuestros pacientes y hemos decidido abrir nuestro consultorio a cierto número de miembros de Medicaid y PeachCare for Kids bajo el programa de ***Georgia Better Health Care*** («Mejores Cuidados de Salud de Georgia»). Si usted tiene interés en unirse a nuestro consultorio o si quiere continuar, pedimos que llene este formulario.

Si tiene una pregunta o duda, llámenos a nuestra oficina al teléfono ________________________ y hable con ____ ____________________________; o puede llamar a las oficinas de ***Georgia Better Health Care Member Services*** («Atención al Cliente de Mejores Cuidados de Salud de Georgia») al teléfono 1-866-211-0950 (sin cobro alguno) o al (770) 570-3373. También puede llamar al 1-877-427-3224, el teléfono gratuito de ***PeachCare Member Services*** («Atención al Cliente de PeachCare»).

____

(Nombre y apellido del proveedor médico, cargo – LETRA DE IMPRENTA)

____

(Dirección del proveedor médico) Calle Ciudad Estado Código postal

(El paciente se queda con la parte superior del formulario)

= =

(Proveedor)

Yes, ____ would like to serve as a ***GBHC / PeachCare***
(Provider name, title - PRINTED)

primary care provider for the ***GBHC / PeachCare*** member(s) listed below:

________________________________ ____

(GBHC Provider number) (GBHC Provider Signature)

Patient information:

________________________________ ___________________ ___________________

(Name – PRINTED) (Member Identification) (Phone number)

________________________________ ___________________

(Name - PRINTED) (Member Identification)

________________________________ ___________________

(Name - PRINTED) (Member Identification)

________________________________ ___________________

(Name - PRINTED) (Member Identification)

________________________________ ___________________

(Patient or Guardian signature) (Date)

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