PCP Re-Assignment Request

Fax to 503-416-1328

Please verify patients are enrolled with CareOregon prior to submitting this form to prevent an unauthorized disclosure of protected health information.

Requests are typically processed within five (5) business days. Reassignment can be confirmed by reviewing your clinic's roster through CareOregon Connect at http://www.careoregon.org/Providers/ProviderPortalLogin.aspx or through OneHealthPort at http://www.onehealthport.com/.

CLINIC INFORMATION

Today's Date:_____/____/_____Your Name: _____

Clinic Name: _____

Telephone #: _____ Fax #:_____

MEMBERS TO REASSIGN

Member Name	DOB	Member ID	Reason for Change (Choose one)	
			Member is established at another clinic and should be reassigned as indicated below	Your clinic requests to be the PCP for this member

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