HealthPlan OF SAN MATEO
Healthy is for everyone

Change of Address Form

How to update your address

1. Fill out this form for yourself only. Fill out a separate form for each member of your household affected by the address change.
2. Review the entire form to make sure it is complete and accurate, then sign at the bottom.
3. Submit the form either by mail, email or fax using the contact information for your plan below.

If you have any questions or require assistance, please call HPSM at the phone number for your plan below.

CareAdvantage members:
Mail: 801 Gateway Blvd., Suite 100
c/o The CareAdvantage Unit
South San Francisco, CA 94080
Email: **CareAdvantageSupport@hpsm.org**
Fax: **650-616-2190**
Phone: **1-866-880-0606**
TTY: **1-800-735-2929** or dial **7-1-1**

Medi-Cal, San Mateo County ACE and Healthworx (HMO) Members
Mail: 801 Gateway Blvd., Suite 100
c/o Member Services
South San Francisco, CA 94080
Email: **MemberServicesSupport@hpsm.org**
Fax: **650-616-8581**
Phone: **1-800-750-4776** or **650-616-2133**
TTY: **1-800-735-2929** or dial **7-1-1**

Member Information *(please print)*

Last Name _____ First Name _____ HPSM Member I.D. Number _____

Date of Birth _____ ☐ Male ☐ Female Gender _____ Your Primary Language _____

Home Phone _____ Cell Phone _____

Please check the box for the program you are enrolled in:

☐ CareAdvantage ☐ HealthWorx HMO ☐ Medi-Cal ☐ San Mateo County ACE

Mailing Address *(please print)*

Street Address _____ Apt / Unit # _____

City _____ State _____ Zip Code _____

☐ Check this box if your mailing address and home address are the same.

Home Address *(if different from mailing address)*

Street Address _____ Apt / Unit # _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

See the top of this page for instructions on returning completed forms to HPSM.

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Primary Care Provider (PCP) Change Form

How to choose a primary care provider that is right for you;

1. Use the online search form at www.hpsm.org/provider-search to search by provider name, health plan, location or type of provider. You can also refer to your printed provider directory to browse the list of all providers in your plan.
2. Choose two providers (first and second choice, in case your first choice is not available) that are accepting new patients from your plan.
3. Enter the name of the provider and the NPI number for *PCP Choice 1* and *PCP Choice 2*
4. Review the entire form to make sure it is complete and accurate, then sign at the bottom.
5. If you need to report a change of address, complete the form on the reverse side.
6. You can mail this form to HPSM, 801 Gateway Blvd., Suite 100, South San Francisco, CA 94080, fax to the appropriate number below or email it to **customersupport@hpsm.org.**

If you have any questions or require assistance, please call HPSM:

CareAdvantage Members:
Phone: **1-866-880-0606**
TTY: **1-800-735-2929** or dial **7-1-1**
Fax: **650-616-2190**

Medi-Cal, San Mateo County ACE and Healthworx (HMO) Members
Phone: **1-800-750-4776** or **650-616-2133**
TTY: **1-800-735-2929** or dial **7-1-1**
Fax: **650-616-8581**

Member Information *(please print)*

Last Name _____ First Name _____ HPSM Member I.D. Number _____

Date of Birth _____ ☐ Male ☐ Female Gender _____ Your Primary Language _____

Home Phone _____ Cell Phone _____

Please check the box for the program you are enrolled in:

☐ CareAdvantage ☐ HealthWorx HMO ☐ Medi-Cal ☐ San Mateo County ACE

Primary care provider selections *(please print)*

PCP Choice 1 _____ NPI Number _____ PCP Choice 2 _____ NPI Number _____

I understand that if I do not choose a PCP, HPSM may automatically assign me a PCP.

I understand and agree to seek care only through my PCP for all health care services unless I need emergency care. I will see my PCP for all non-emergency care unless I request a transfer to another doctor, my doctor discontinues their contract with the HPSM, or I am no longer eligible with HPSM.

I understand that PCP changes are effective on the 1st of the following month after the form is received.

Signature _____ Date _____