HealthPlan OF SAN MATEO

801 Gateway Blvd., Suite 100, South San Francisco, CA 94080

Primary Care Physician Selection/Change of Address Form

Instructions

Please fill out this form for yourself or for any member(s) of your household who receives HPSM CareAdvantage (HMO SNP), HPSM CareAdvantage Cal MediConnect (Medicare–Medicaid Plan), HealthWorx, Healthy Kids, Medi-Cal, or San Mateo County ACE through Health Plan of San Mateo (HPSM).

Please sign this form on the bottom line. You can mail this form to HPSM, 801 Gateway Blvd., Suite 100, South San Francisco, CA 94080 or fax to the appropriate number below.

If you have any questions about this form, please call HPSM:

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

Members of:
HealthWorx | Healthy Kids | Medi-Cal | San Mateo County ACE
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 I.D. Number

Date of Birth

Gender ❑ Male ❑ Female

Your Primary Language:

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

❑ CareAdvantage ❑ CareAdvantage CMC ❑ HealthWorx ❑ Healthy Kids ❑ Medi-Cal ❑ San Mateo County ACE

Change of Address

Please **print** the new address below.

Street Address (Change of Address) | Apt / Unit Number | Home Telephone

City | State | Zip Code | Cell Phone

PCP Selection / Change (Please print)

- Please choose from the Provider List provided.
- Please make ***two*** choices in case your First choice is not available.

*** If you do not choose a PCP, HPSM may automatically assign a PCP.**

PCP Choice 1 | PCP Choice 2

I understand and agree to seek care only through my Primary Care Physician for all health care services unless I need emergency care.

I understand my HPSM ID Card will contain the effective date of my PCP selection and that my selection of that doctor will continue unless I request a transfer to another doctor, or my doctor discontinues his/her contract with the Plan, or I am no longer eligible with HPSM. I understand that if my coverage is discontinued and then restored, I need to contact HPSM to report my Primary Care Physician selection.

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

Signature | Date

HealthPlan OF SAN MATEO
801 Gateway Blvd., Suite 100, South San Francisco, CA 94080

選擇主治醫生 / 地址變更表

說明

請為自己或家中通過 Health Plan of San Mateo (HPSM) 領取 HPSM CareAdvantage (HMO SNP)、HPSM CareAdvantage Cal MediConnect (Medicare–Medicaid Plan)、HealthWorx、Healthy Kids、 Medi-Cal (加州低收入醫療保險 – 白卡)、或 San Mateo County ACE 等福利的成員填寫此表格。

請務必在本表格最後一行簽名。您可將此表格郵寄至 HPSM, 801 Gateway Blvd., Suite 100, South San Francisco, CA 94080; 或可傳真至以下相關號碼。

若對本表格有任何疑問，請致電 HPSM:

會員:
CareAdvantage | CareAdvantage CMC
1-866-880-0606
TTY: **1-800-735-2929** 或撥 **7-1-1**
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TTY: **1-800-735-2929** 或撥 **7-1-1**
傳真: **650-616-8581**

會員資訊 (以正體書寫)

姓氏 | 名字 | HPSM 會員卡號碼

出生日期

性別 ❑ 男性 ❑ 女性

您的主要語言:

請勾選您要登記參加計劃的方塊:

❑ CareAdvantage ❑ CareAdvantage CMC ❑ HealthWorx ❑ Healthy Kids ❑ Medi-Cal ❑ San Mateo County ACE

地址變更

請以**正楷填寫**下列新地址。

街道地址 (變更地址) | 公寓 / 單位號碼 | 住家電話

城市 | 州 | 郵遞區號 | 手機

選擇/變更主治醫生 (請以正楷填寫)

- 請由提供者名單做選擇。
- 請選擇兩項，以免您的首選不適用。

*** 如果您沒有選定醫生，HPSM 會自動為您指派主治醫生。**

主治醫生第 1 人選 | 主治醫生第 2 人選

本人了解且同意除非我需要急診護理服務，否則我只能透過主治醫生尋求所有健康護理服務的協助。

本人了解我的 HPSM 會員卡包含我所選主治醫生的生效日期，且本人了解除非我要求轉用另一位醫生，或者我的醫生終止與本計劃的合約，或者我不再符合資格參加 HPSM，否則我選擇的醫生將繼續為我服務。本人了解若我終止保險後再復保，我必須與 HPSM 聯絡並告知我的主治醫生人選。

本人了解主治醫生的變更是在我們收到表格後隔月 1 日才生效。

簽名 | 日期