HealthPlan OF SAN MATEO

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

www.hpsm.org

PROVIDER SELECTION FORM FOR HPSM PHYSICIANS ACCEPTING ESTABLISHED PATIENTS ONLY (EPO)

Our records indicate that your office is restricted to accept HPSM members who are Established Patients Only. This document will serve as consent to allow a member to be assigned to your office for Primary Care Services. In order for this change to take place this form must be signed by an authorized employee of your practice and the member (if available). All changes will be effective the first day of the following month as long as the member remains eligible for HPSM Medi-Cal.

Date _____

To: Health Plan of San Mateo, Member Services Department
Fax: 650-616-8581

Provider Name/ Group: _____ Provider Number: _____

Contact Person/ Title: _____

Telephone #: _____ Fax#: _____

I am authorizing this member to be assigned to this office for Primary Care

☐ YES ☐ No

Authorizing Staff Signature _____ Print Staff Name _____

I am authorizing the above provider to be my Primary Care Physician.

If form is received by the 22nd of the month, effective date is the 1st of the following month.

Print Member's Name _____ Guardian/Member Signature _____

Member /dentification Number _____ Member Date of Birth _____

If you have any questions you may call a Member Services Representative at **1-800-750-4776**.

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