801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1

www.hpsm.org

Provider Request for Member Reassignment

Provider Information

____	____
PCP/Provider Requesting	Telephone Number

Member's Information

____	____
Member's Name	Telephone Number
____	____
HPSM ID Number	Date of Birth (XX/XX/XXXX)

Reason for Request

☐ Abusive or disruptive ☐ Missed appointments/no show ☐ Inappropriate behavior ☐ Late for appointments
☐ Failure to comply with medical advice ☐ Other (Describe): ____

Were at least three warning letters (one certified) sent to the member for the issue above? ☐ Yes ☐ No
Did you try to resolve the above issue with the member ☐ Yes ☐ No
Have you completed HPSM's Complex Management form? ☐ Yes ☐ No
If yes, describe: ____

Please include a description of the issue and include documentation of all communication that you have had with the member that pertains to the reason for your request. Also, provide copies of letters sent to the member and medical records that encompasses documentation of the issue.

Send this form: **Fax: 650-616-8046** **Email: psinquiries@hpsm.org**

The Provider Services Department will notify you within 14 business days. For more information regarding HPSM's Member Reassignment policy: ***https://www.hpsm.org/provider/resources/provider-manual***

For HPSM Use Only:

Received by Provider Services: ___________________ Forwarded to Care Coordination: _________________
G&A Report Requested: _________________________ G&A Report Sent to PS: _________________________
Letter Sent to HPSM Member: ___________________ ☐ Approved ☐ Denied

Medical Director Signature: ____ Date: _______________________

Updated 5/2024