HealthPlan OF SAN MATEO
Healthy is for everyone

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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

Signature: _____ Date: _____
☐ Provider Network Manager ☐ Medical Director