MOLINA HEALTHCARE

Primary Care Provider (PCP) Selection Form

Please complete this form, and mail it to:
Molina Healthcare of New York, Inc.
Attention to: Member Enrollment
1776 Eastchester Road
Bronx, NY 10461

Fax: (315) 234-5916

Please print clearly.

Member Name: _____

Member ID #: _____ **Member Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone number: (_____**)** _____

Please name the Primary Care Provider (PCP) you would prefer to see:

_____

Signature: _____ **Date:** _____

You can also select or change your PCP online:

1) Member Portal: https://member.molinahealthcare.com/
2) Provider Online Directory: https://providersearch.molinahealthcare.com

If you have questions, regarding this letter, call Member Services for this information at (800)223-7242 (TTY: 711), Monday – Friday, 8:00 a.m. to 6:00 p.m.

For Providers:

Once the member completes the form, please fax it to (315) 234-5916 (Attention: "Member Enrollment"). The member may also email this form at MHNYEnrollment@molinahealthcare.com