BlueCross BlueShield of Western New York

PO Box 80 • Buffalo, New York 14240-0080

Primary Care Physician (PCP) Change Form

This form ***will not be processed*** if the signature of the member or his/her parent or guardian is not provided below.

Today's Date: _____

To Be Completed by the Member

Member ID#: _____

Group#: _____

Member Name: _____
(Please print)

Parent/Guardian Name: _____
(if applicable) ***(Please print)***

Name of New Medical PCP: _____

ADDRESS OF NEW LOCATION (below):

Effective Date of Change: ☐ Today ☐ First day of the upcoming month
(check one box)

Signature of Member or Parent/Guardian: _____
(Signature required)

Fax the completed form to Customer Service at:
State and Federal Members: 1-888-333-4316
Commercial/ASO Members: 1-866-605-9524