Your Community Physicians
Chinese Community Health Care Association
827 Pacific Ave., San Francisco, CA 94133
Tel: (415) 216 - 0088 Fax: (415) 216 - 0081
www.cchca.com

CCHCA PHYSICIAN STATUS CHANGE REQUEST FORM

This form is to be used to change physician preferences for acceptance of patients and listing in the Physician Directory. **YOU MUST PROVIDE A HUNDRED AND TWENTY (120) DAYS NOTICE OF A CHANGE**.

Please fill in the appropriate responses and return to the CCHCA office. Physician changes are subject to acceptance by the CCHCA. Changes are effective for ALL PROGRAMS of CCHCA unless otherwise specified.

1) I WISH TO CHANGE MY STATUS:

A) _____ I wish to reinstate my panel

_____ I do not wish to remain as a Primary Care Physician.

_____ I wish to maintain my present panel and cannot accept further members *(For Primary Care Physician only)*

_____ I do not wish to maintain my present panel.
(*Health Plan office will contact your panel members to have them change to another PCP. Until the change is effective you will remain the PCP status.* **(For Primary Care Physician only)**

B) I wish to be listed as a: _____ Primary Care Physician Specialty: _____

_____ Specialist Specialty:_____

(All specialists MUST participate in all CCHCA contracted HMO plans)

2) I WISH TO LIMIT MY PRACTICE TO:_____(Specialty)

3) OTHER STATUS CHANGES: _____

_____

_____

4) THESE CHANGES ARE EFFECTIVE FOR THE FOLLOWING HEALTH PLANS:

_____ **San Francisco Health Plan**

I wish this to be effective on: _____ (Date)

Physician Name (Please print): _____

Physician Signature:_____ Date: _____

Please return the form to CCHCA Provider Relations Team
Fax: (415) 216-0081 Email: Provider.Relations@cchca.com