WellCare®

PCP REQUEST FOR TRANSFER OF MEMBER

Physician: _____ Member: _____

ID#: _____ ID#: _____

Telephone: _____ Telephone: _____

Fax: _____ ☐ Medicare ☐ Medicaid ☐ Exchange

Please select the appropriate reason for termination of your relationship with this member:

☐ Disruptive behavior ☐ Non-compliance with treatment

☐ Chronically Missed appointments: Date: _____ Date: _____

☐ Is this member on an active treatment plan? ☐ Yes ☐ No
If Yes, please provide brief description in space below.

Description:

_____

_____

_____

_____

Please submit a copy of the progress notes from the member's medical record that documents your concern.

Physician signature: _____ Date: _____

Instructions:
This form is intended solely for PCP requesting "Termination of a Member" (refer to Wellcare Provider Manual). Complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the member until such time that written notification is received from Wellcare stating, "The member has been transferred from the provider's practice, and such transfer has occurred." Providers are not allowed to communicate directly with plan members regarding intent to transfer a member from their panel.
After receiving adequate documentation and making an administrative ruling, the plan will contact members regarding any changes in PCP assignments.

Fax request to: Customer Service at 1-855-619-8184