

## ***Provider Request for Member Deletion from PCP Assignment***

PCP name:		PCP phone number:	
Member name:		Member ID number:	
Date:	Member date of birth:	Member phone number:	
<b>Reason for request (Select all that apply.)</b>			
<input type="checkbox"/> Excessive no shows <input type="checkbox"/> Urgent or emergency care abuse <input type="checkbox"/> Medication abuse <input type="checkbox"/> Other		<input type="checkbox"/> Member not allowing PCP to manage care <input type="checkbox"/> Unreasonable demands for referrals <input type="checkbox"/> Abusive or disruptive behavior <input type="checkbox"/> Unsatisfactory doctor/patient relationship (explain below)	
If you selected <i>excessive no shows</i> or <i>urgent or emergency care abuse</i> above, list any applicable dates.			
Have you ever seen this member? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What are the specific circumstances that contributed to the provider making this request?			
If you selected <i>medication abuse</i> above, what is the member doing to obtain more medication than necessary?			
Add additional comments here:			
Mail request to:		UniCare Health Plan of West Virginia, Inc. P.O. Box 91 Charleston, WV 25321-0091	