

**CHANGE OF PRIMARY CARE PROVIDER
REQUEST FORM**



Patient Name: _____ **Date:** _____

SSN: _____ **Current Provider** _____

To better serve you we need to know why you wish to change Primary Care Providers. Please mark all that apply and use the comment area provided.

- I was not included in decisions/my medical concerns were not addressed
- It was difficult for me to understand my Primary Care Provider.
- I did not get along with my Primary Care Provider/Incompatible.
- My Primary Care Provider would not provide me with medications I felt I needed.
(I understand that my new provider may not give me these medications either)
- Change of Location (Please note travel pay is paid based on distance to closest VA/clinic)

Comments (Explain your concerns):

Requests will be denied if any of the following apply:

- You have had one provider change in the past 12 months.
- If there is no reason given for the change.

Veteran Signature and Date

<p><u>For VA Use Only</u></p> <p>Clinical Review Decision Recommend Approval / Disapproval Date: _____</p> <p>_____</p> <p>Signature of Approving Official (MD)</p> <p>Assign Veteran to a team with: MD ___ NP ___ Either _____ Other information: _____</p> <p>If denied, name of provider who contacted the Patient: _____</p>

RETURN FORM TO:

**Cheyenne VA Medical Center
Attn: Patient Advocate
2360 E Pershing Blvd
Cheyenne, WY 82001**

For Questions, please call (307) 778-7550, press "0", then "1"