

Change form



Member changes must be received by Priority Health within 31 days of the event.

Priority Health • MS 2275 • 1231 E. Beltline NE, Grand Rapids, MI 49525 • Fax to: 616.942.5242

Member information

Member's last name	First name	Middle initial	Social Security number — —	Member ID number
Email			Phone	

<input type="checkbox"/> Name change For: <input type="checkbox"/> Member <input type="checkbox"/> Dependent	New last name	First name
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<input type="checkbox"/> Address/phone change For: <input type="checkbox"/> Member <input type="checkbox"/> Dependent	Street	City, State	ZIP	Phone
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Dependent information (if you have more than 4 dependent changes, complete an additional change form)

1	Last name	First name	Middle initial	Social Security number — —	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Birth date / /	Relation to member	Address		City, State
	Has this dependent ever seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care provider (REQUIRED for HMO & POS)	PCP address	
2	Last name	First name	Middle initial	Social Security number — —	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Birth date / /	Relation to member	Address		City, State
	Has this dependent ever seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care provider (REQUIRED for HMO & POS)	PCP address	
3	Last name	First name	Middle initial	Social Security number — —	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Birth date / /	Relation to member	Address		City, State
	Has this dependent ever seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care provider (REQUIRED for HMO & POS)	PCP address	
4	Last name	First name	Middle initial	Social Security number — —	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Birth date / /	Relation to member	Address		City, State
	Has this dependent ever seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary care provider (REQUIRED for HMO & POS)	PCP address	

Authorization

I authorize Priority Health to make the changes indicated above for my dependents and me. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed. *Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.*

x _____
Member signature Date

Completed by employer	<input type="checkbox"/> Plan change (if checked please also check one of the following) <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> HbC <input type="checkbox"/> HRA <input type="checkbox"/> HSA Plan option (if applicable) <input type="checkbox"/> High <input type="checkbox"/> Mid <input type="checkbox"/> Low					
	Employer name	Group number	Sub group number	Sub group <input type="checkbox"/> New <input type="checkbox"/> Existing	Class	Class <input type="checkbox"/> New <input type="checkbox"/> Existing
	Employer/representative signature			Date / /		
	Reasons for additions <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Loss of other coverage (proof required) <input type="checkbox"/> Open enrollment <input type="checkbox"/> Court order (proof required) <input type="checkbox"/> Other _____			Effective date / /		
	Reasons for dependent termination <input type="checkbox"/> Marriage of dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost eligibility <input type="checkbox"/> Other _____			Date participant notified of coverage termination / /	Date coverage ended / /	

For Priority Health use only	Date received / /	Processor	Code	Date processed / /
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