

Date:

Phoenix Health Plan
Abrazo Advantage Health Plan (HMO)
7878 N. 16th St. Suite 105
Phoenix, Arizona 85020

Fax: (602) 674-6613

Attention: Member Services

Subject: Member Reassignment

Member Name:
Date of Birth:

Member AHCCCS ID#:

Dr. _____ is requesting that the above member be removed from his/her panel for the reason given below. As the member's Primary Care Provider I acknowledge my responsibility to provide healthcare in the event of an emergency for a minimum of 30 days from the date of removal.

<input type="checkbox"/> Multiple Missed Appointments Dates of Service:	<input type="checkbox"/> Possible Prescription Abuse
<input type="checkbox"/> Non-Compliance	<input type="checkbox"/> Member/Provider Communications
<input type="checkbox"/> Behavior (Abusive, Threatening, etc)	<input type="checkbox"/> Complex Case, explain below

Please describe the problem in detail:

We acknowledge our responsibility to provide healthcare in the event of an emergency for a minimum of 30 days from the date of removal

Sincerely,

PCP's Name

Signature

Date