Change form

PriorityHealth

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		

☐ **Name change** For: ☐ Member ☐ Dependent	New last name	First name

☐ **Address/phone change** For: ☐ Member ☐ Dependent	Street	City, State	ZIP	Phone

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

☐ **Plan change (if checked please also check one of the following)** ☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **HbC** ☐ **HRA** ☐ **HSA** **Plan option (if applicable)** ☐ **High** ☐ **Mid** ☐ **Low**

Employer name	Group number	Sub group number	Sub group ☐ New ☐ Existing	Class	Class ☐ New ☐ Existing

Employer/representative signature	Date / /
Reasons for additions ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of other coverage (proof required) ☐ Open enrollment ☐ Court order (proof required) ☐ Other _____	Effective date / /
Reasons for dependent termination ☐ Marriage of dependent ☐ Divorce ☐ Death ☐ Lost eligibility ☐ Other _____	Date participant notified of coverage termination / / — Date coverage ended / /
Reason for termination of entire contract ☐ Terminated employment ☐ Lay off ☐ Leave of absence ☐ Changed health plans ☐ Moved out of the area ☐ Death ☐ COBRA terminated ☐ Dissatisfied ☐ Other _____	Date participant notified of coverage termination / / — Date coverage ended / /

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