Primary Care Physician (PCP) Form

network health

As an Network Health Plan member, you are required to select a Primary Care Provider (PCP). Your PCP can be a doctor, nurse practitioner or a physician's assistant. **If you do not select a PCP, one will be selected for you.**

Please choose a PCP from the online listing at www.mhswi.com. You may select a different PCP for each family member. PCPs are listed under Family Practice, General Practice, Internal Medicine, OB/GYN and Pediatrics. Please do not list a clinic or hospital as your PCP. Please choose a PCP from the online listing at www.mhswi.com. If you need help choosing a PCP, our Customer Service staff will be happy to help you at (888) 713-6180, option 1.

1. Member Information

**Required Field*

First Name:_____ MI:_____ Last Name: _____

Forward*Health* ID:* _____ Date of Birth (mmddyyyy): _____

Telephone Number (with area code): _____

Please provide PCP Information

Requested PCP Name: _____

Office Address: _____

City:_____ State:_____ Zip Code: _____

Office Phone (with area code):_____

2. Member Information

**Required Field*

First Name:_____ MI:_____ Last Name: _____

Forward*Health* ID:* _____ Date of Birth (mmddyyyy): _____

Telephone Number (with area code): _____

Please provide PCP Information

Requested PCP Name: _____

Office Address: _____

City:_____ State:_____ Zip Code: _____

Office Phone (with area code):_____

3. Member Information

**Required Field*

First Name:_____ MI:_____ Last Name:_____

Forward*Health* ID:* _____ Date of Birth (mmddyyyy):_____

Telephone Number (with area code):_____

Please provide PCP Information

Requested PCP Name:_____

Office Address:_____

City:_____ State:_____ Zip Code:_____

Office Phone (with area code):_____

4. Member Information

**Required Field*

First Name:_____ MI:_____ Last Name:_____

Forward*Health* ID:* _____ Date of Birth (mmddyyyy):_____

Telephone Number (with area code):_____

Please provide PCP Information

Requested PCP Name:_____

Office Address:_____

City:_____ State:_____ Zip Code:_____

Office Phone (with area code):_____

Directions: Please mail this form to Network Health Plan Customer Service, 10700 W. Research Drive, Suite 300, Milwaukee, WI, 53226. If you have questions about how to complete this form or want to make this request over the phone, please call the Network Health Plan Customer Service Department, from 8 a.m. to 7 p.m. (CST), Monday through Friday, at 1-888-713-6180 TDD/TTY (Wisconsin Relay): 1-800-947-3529.