***MY HEALTH GPS***

**PROVIDER CHANGE FORM**

**TO BE COMPLETED BY/FOR *MY HEALTH GPS* BENEFICIARIES**

The *My Health GPS* Provider Change Form must be completed in full. Please complete the form and submit by secure email to [myhgps@dc.gov](mailto:myhgps@dc.gov).

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Name of Beneficiary: | Date of Birth: | Medicaid Number: |
| Current *My Health GPS* Provider: | Managed Care Organization (MCO) if applicable: | |

I understand that I may request to change providers at any time and that the request to change providers will be effective based on the following:

* If my request to change providers is received by DHCF prior to the twentieth (20th ) day of the month, it will be effective the first day of the month following the month in which DHCF was notified;
* If my request to change providers is received by DHCF on or after the twentieth (20th) day of the month, it will be effective the first day of the second month following the month in which DHCF was notified.

I understand that I remain eligible to receive *My Health GPS* services from my current *My Health GPS* provider until the effective enrollment date with my new provider.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of Beneficiary or Legal Guardian (if applicable) |  | If Legal Guardian’s Signature, print name |  | Date Signed |

**FOR DHCF USE ONLY**

|  |  |  |
| --- | --- | --- |
| Date Form Received: | Effective Date of New MHGPS Assignment: | Date Beneficiary Notified: |