CommunityCare

CHANGE FORM

Please fax form to (918) 594-5349 or e-mail to communitycareenrollment@ccok.com

Open Enrollment Plan Changes ONLY	
Changing from:	***Changing to:***
❑HMO ❑Full Network ❑Select Network	❑HMO ❑Full Network ❑Select Network
❑PPO ❑Full Network ❑Select Network	❑PPO ❑Full Network ❑Select Network
❑POS	❑POS

***REMINDER:** If you are making a change outside of your open enrollment period, please include the appropriate documentation with this form, such as a copy of a marriage certificate, divorce decree, certificate of creditable coverage from prior carrier (for loss of coverage), etc.*

Effective Date of Change _____

CommunityCare ID Number	Employer Name		Group Number	
Employee Name Last	First	Middle Initial	Social Security Number	
Street Address	City		State	ZIP code
Home Telephone ( )	Work Telephone ( )	Extension		

Change as indicated:

❑ Name Change *List former name:* _____

❑ Address/Phone Change *List former address/phone:* _____

Name Change as a Result of Marriage

If a name change is being made as a result of marriage and the employee does not request the addition of any new eligible dependent(s) at this time, this form shall serve as waiver of dependent coverage and the procedure for late enrollment of dependent(s) shall apply to any subsequent request for dependent coverage. *Note: Outside of open enrollment, a copy of your marriage certificate is required with this form.*

Employee Signature _____ **Date** _____

Request to Add Dependent(s):

Please list all dependent(s) for whom you are requesting coverage. Attach a certificate of creditable coverage if outside open enrollment period.

Name	Relationship	Social Security Number	Date of Birth	Sex	PCP Selection	Established Patient?

Does this dependent(s) have other coverage? If so, please list health insurance carrier(s): _____

Reason for change: _____ Date of change: _____

Request to Drop Coverage

Under the coverages issued to my employer, I do not wish coverage for:

- ❑ **Myself and my dependent(s) *(if any)***
- ❑ Spouse
- ❑ Child(ren) *List name(s):* _____

Reason for Change

- ❑ Disenrollment *(changing health insurance carriers, reduction in hours, voluntuary disenrollment, etc.)*
- ❑ Terminating employment
- ❑ Divorce *(outside of open enrollment, please include copy of divorce decree)*
- ❑ Other: _____

❑ Change of Primary Care Physician

❑ Changing Hospital Network *(only during open enrollment)*

Please note that the effective date of the PCP change will be on the first day of the month if the request is received before the 15th of the previous month.

Last Name	First Name	New PCP	PCP's Hospital Network

All PCP changes must be approved by CommunityCare before becoming effective. All existing referrals or precertifications made by your former Primary Care Physician are canceled as of the effective date of the change to your new Primary Care Physician. Your new Primary Care Physician is responsible for your care as of the effective date.

Employee Signature _____ **Date** _____

Employer Signature ***(if employee not present)*** _____