Medical Panel Transfer Request Form

Instructions:

The following information must be completed for your practice to transfer to another PCMH medical panel. The transferring practice **and** the Designated Provider Representative (DPR) of the receiving panel must fill out each assigned section and sign below in the signature section at the bottom of the form. Please return this form to the Practice Consultant of the panel your practice is joining.

TRANSFERRING PRACTICE INFORMATION			
Practice Name	Practice Tax ID		
Regional Practice Provider Number	Primary Office Telephone Number		
Practice NPI Number (Type II)	Practice E-mail Address*		
Primary Practice Address	City	State	Zip
Current Medical Panel Number	Current DPR Name		
New Medical Panel Number	New DPR Name		

DPR INFORMATION			
DPR Full Name	DPR Title	DPR Phone Number	
DPR Primary Practice Address	City	State	Zip
DPR E-mail Address*			
Current Medical Panel Number			
Name of Practice Joining Medical Panel			

SIGNATURE	
Signature of Practice Representative	Date
Signature of DPR	Date

* E-mail addresses starting with sales@, info@, webmaster@, etc. are considered role accounts and are blocked from our system. Please provide your business or practice email address when entering your information. You will not be able to access our system without your business or practice email address.