



1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

866-606-3700 (TTY 711)
ILmeridian.com

Primary Care Provider Reassignment Form

Primary Care Provider (PCP) Information

Date: _____
Office Name: _____
Office Address: _____
City _____ State _____ Zip: _____
Office Phone: _____ Office Fax: _____
Staff Member Initiating Request: _____
PCP Name: _____ NPI #: _____
PCP Office Location: _____

Member Information

Member's Full Name: _____
Member's Date of Birth: _____ Meridian Member ID: _____

Meridian Member Authorization

*Signature of Member, Parent, or the Responsible
Party is required to approve PCP change*

Printed Name _____

All fields must be completed. Failure to provide all required information above will result in this request not being processed.

For questions, please call Member Services at **866-606-3700**.

Fax completed Primary Care Provider Reassignment Form to: 844-751-1870.



300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

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Discharge Medication

Name	Dose	Quantity	Date	Meds	Script

Use additional forms if necessary. Please fax to Meridian's Behavioral Health department at 312-508-7200.