Kern Family Health Care
The Friendly Face
Of Kern Health Systems

PRIMARY CARE PHYSICIAN DESIGNATION FORM

Member Name: _____

Member SS#: _____

Member Medi-Cal ID#: _____

Member Date of Birth: _____

Member Address: _____

_____

_____

Member Phone Number: _____

Current Designated Physician/Clinic: _____

I would like to select_____ as my primary care provider.
Physician/Clinic

I understand that this selection will take place at the beginning of the following month if I am changing my Primary Care Physician.

_____ _____
Member Signature Date

PLEASE FAX THIS FORM TO THE MEMBER SERVICES DEPARTMENT AT (661) 664-5179
(For the change to take effect the first of the month, this form must be received by the 24th of the previous month)

For KFHC Use Only
Received Date: _____ Change Made to: _____ By:_____ Date:_____

New ID card Generated ____ Yes ____ No
Comments: _____

Revised 2/2004