AAMG
All American Medical Group

Provider Relations Department
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AAMG PHYSICIAN STATUS CHANGE REQUEST FORM

This form is to be used to change physician preferences for acceptance of patients and listing in the Physician Directory.
YOU MUST PROVIDE A HUNDRED AND TWENTY (120) DAYS NOTICE OF A CHANGE.

Please fill in the appropriate responses and return to the AAMG office. Physician changes are subject to acceptance by AAMG. Changes are effective for **ALL PLANS** of AAMG unless otherwise specified.

1) I WISH TO CHANGE MY STATUS:

A) _____ I wish to reinstate my panel

_____ I do not wish to remain as a Primary Care Physician.

_____ I wish to maintain my present panel and cannot accept further members ***(For Primary Care Physician only)***

_____ I do not wish to maintain my present panel.

(*Health Plan office will contact your panel members to have them change to another PCP. Until the change is effective you will remain the PCP status.* ***(For Primary Care Physician only)***

B) I wish to be listed as a: _____ Primary Care Physician Specialty: _____

_____ Specialist Specialty: _____

(All AAMG Physicians MUST participate in all AAMG contracted HMO plans)

2) I WISH TO LIMIT MY PRACTICE TO: _____ **(Specialty)**

3) OTHER STATUS CHANGES: _____

_____

_____

4) THESE CHANGES ARE EFFECTIVE FOR THE FOLLOWING HEALTH PLANS:

_____ **Aetna HMO**
_____ **Anthem Blue Cross HMO**
_____ **Anthem Blue Cross Medi-Cal**
_____ **Anthem Blue Cross Medicare**
_____ **Blue Shield HMO**
_____ **Brand New Day**
_____ **Health Net of California HMO**
_____ **San Francisco Health Plan**
_____ **Scan Health Plan**
_____ **Wellcare by HealthNet**

I wish this to be effective on: _____ **(Date)**

Physician Name (Please print): _____

Physician Signature: _____ Date: _____

Please return the form to AAMG Provider Relations Team
Fax: (415) 216-0081 Email: ProviderRelationsNorCal@networkmedicalmanagement.com