



Healthfirst, Inc.
P.O. Box 5165
New York, NY 10274-5165

Member Status Change Request Form

1-866-GO-FOR-HF (1-866-463-6743)

Date of Change
Office Use - Initials

Reason(s) For Change: <input type="checkbox"/> Change of Address/Telephone <input type="checkbox"/> Request for ID Card <input type="checkbox"/> Notification of Newborn <input type="checkbox"/> Request for PCP Change <input type="checkbox"/> Request for OB/GYN Change				
HEAD OF HOUSEHOLD LAST NAME		FIRST NAME	MIDDLE INITIAL	YOUR DSS FAMILY CASE NUMBER
NEW STREET ADDRESS		CITY, STATE, ZIP CODE		NEW PHONE (Area Code and No.)
PREVIOUS STREET ADDRESS		CITY, STATE, ZIP CODE		PREVIOUS PHONE (Area Code and No.)
REQUEST FOR DUPLICATE ID CARD(S)				
(Please provide the Medicaid Client or Healthfirst Identification Number)				
NAME		CIN # or Healthfirst ID #		DATE OF BIRTH
NAME		CIN # or Healthfirst ID #		DATE OF BIRTH
NAME		CIN # or Healthfirst ID #		DATE OF BIRTH
COMPLETE THIS SECTION TO CHANGE YOUR PCP OR OB/GYN. YOU WILL AUTOMATICALLY RECEIVE A NEW MEMBER ID CARD. PCP AND OB/GYN CHANGES WILL BECOME EFFECTIVE THE FIRST OF THE FOLLOWING MONTH AFTER THIS FORM IS RECEIVED.				
NAME		CIN # or Healthfirst ID #		
Previous PCP	PCP #	New PCP	PCP #	
Previous OB/GYN	OB/GYN #	New OB/GYN	OB/GYN #	
NOTIFICATION OF NEWBORN				
MOTHER'S NAME		CIN # or Healthfirst ID #		
NEWBORN NAME		NEWBORN CIN #	SEX	DATE OF BIRTH
NEWBORN NAME		NEWBORN CIN #	SEX	DATE OF BIRTH

HEAD OF HOUSEHOLD SIGNATURE

DATE SIGNED