

# MEDICAL ASSISTANCE MANAGED CARE PROVIDER SELECTION FORM



Select a Primary Care Provider from the list of available providers. Providers with an “\*” next to their names indicate that they have full caseloads and are not accepting new patients. Only recipients who are current patients may select a provider who has a full caseload.

Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, and Medical Residents may be listed on the provider list but are not primary care providers. To access medical care from these providers, select the primary care provider they are listed under.

**NOTE:** All Managed Care eligible family members do not have to choose the same Primary Care Provider.



- I understand that I **MUST** choose one Primary Care Provider for each eligible managed care family member by completing the section below AND returning the completed form to the Department of Social Services.
- If I do not choose a Primary Care Provider, the State Office of Medical Services will choose a Primary Care Provider for me and all other managed care eligible family members.
- I understand that I may request to change my Primary Care Provider at any time.

• **Please complete this Selection Form and mail to:**  
(You may also take this form to your local Department of Social Services Office and they can mail it for you).

**Medical Services  
700 Governor’s Dr  
Pierre, SD 57501**

|   | MANAGED CARE<br>RECIPIENT’S NAME<br><small>(Family members eligible for Medical Assistance)</small> | RECIPIENT<br>ID NUMBER<br><small>(from notice or ID card)</small> | PRIMARY CARE<br>PROVIDER NAME<br><small>(from Provider list)</small> | PCP<br>CODE<br><small>(from Provider list)</small> |
|---|---|---|--|--|
| 0 |   |   |  |  |
| 1 |   |   |  |  |
| 2 |   |   |  |  |
| 3 |   |   |  |  |
| 4 |   |   |  |  |
| 5 |   |   |  |  |
| 6 |   |   |  |  |

**I understand the Medical Assistance Managed Care Program rules and requirements and also understand that by not following those rules and requirements I may be responsible for payment of medical bills. Refer to the *Medical Assistance Program Recipient Handbook* for more information.**

Your Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_