healthfirst®
Health Insurance for New Yorkers

Member Status Change Request Form

This form has been provided so that you may request changes to your demographic information or Primary Care Provider (PCP), request a replacement ID card, and/or notify Healthfirst of a newborn dependent. If you enrolled for Medicaid/Child Health Plus (CHP) through NY State of Health (NYSOH), all demographic account changes must be reported to NYSOH directly at **nystateofhealth.ny.gov** and should NOT be completed on this form. Be sure to select the type of request(s) and fill in the required information in the appropriate field as needed. **You may submit more than one request at a time.**

Below are the instructions for completing each section of this form:

Demographic Changes

Request to change email, mailing address, home address, and phone number(s)

- Select the field that you want to change: Home Address, Mailing Address, Email Address, Home Phone, or Cell Phone. You may make more than one change at a time
- Write the member's name as shown on the Healthfirst ID card (First Name, Last Name)
- Write the member's Healthfirst ID # found on the ID card
- Write the previous and the new information in the appropriate field(s)

ID Card Replacement

Request for Healthfirst replacement member ID card(s)

- Write the member's name as shown on the ID card (First Name, Last Name) for whom the ID card is being requested
- Write the member ID #
- Write the member's Date of Birth
- You may request a Healthfirst ID card for more than one member at a time

PCP Change

Request to change the Primary Care Provider (PCP)

- Write the member's name as shown on the Healthfirst ID card (First Name, Last Name) for whom the PCP change is being requested
- Write the member's Healthfirst ID # found on the ID card
- Write the new PCP's name, address, office phone number, and provider ID # (if available)
- Write the previous PCP's name, address, office phone number, and provider ID # (if available)
- You may use one form to request a PCP change for more than one member under the same subscriber account

Newborn Notification

Notify Healthfirst of newborn(s)

- Write the member's (mother's) name as shown on the ID card (First Name, Last Name)
- Write the member's (mother's) Healthfirst ID # found on the ID card
- If you have selected a PCP for your newborn, please write the newborn's PCP information, including the name, address, office phone number, and provider ID # (if available)
- Write the newborn's name (First Name, Last Name), Date of Birth, Gender, and Medicaid Client Identification Number (CIN #) if available

Member Attestation

Sign and date the form

- After making sure that all the information is complete, please sign and date the form

Member Feedback

Member feedback to help us improve the form

- To help us improve the form, please let us know if this form is easy to fill out by checking "Yes" or "No". If "No" is selected, please explain your reason

If you have any questions or need additional help with filling out this form, please call our Member Services department at 1-866-463-6743, TTY English 1-888-542-3821, TTY Español 1-888-867-4132, Monday to Friday, 8:00am–6:00pm. We can help you in English, Spanish, Chinese, and other languages. If you require in-person assistance with filling out this form, you may visit the nearest Healthfirst Help Center.

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Member Services Department
Healthfirst, Inc., P.O. Box 5165, New York, NY 10274-5165
1-866-463-6743 | TTY: 1-888-542-3821 | Fax: 1-212-801-3250
Monday through Friday, 8am–6pm

REASON(S) FOR CHANGE:

☐ Address/Telephone/Email
☐ Request for ID Card
☐ Request for PCP Change
☐ Notification of Newborn

PLEASE CHECK WHICH FIELD IS BEING CHANGED:

☐ Home Address
☐ Mailing Address
☐ Email Address
☐ Home Telephone
☐ Cell Phone

Individuals who enrolled for Medicaid/CHP through NY State of Health must report any changes to their account to NY State of Health and do not need to complete this form.

HEAD OF HOUSEHOLD

Last Name		First Name	Middle Initial	Identification #
NEW Home Address	apt/fl	City, State, Zip Code	**NEW** Home Phone (Area Code and No.)	
NEW Mailing Address	apt/fl	City, State, Zip Code	**NEW** Cell Phone (Area Code and No.)	
Previous Home Address	apt/fl	City, State, Zip Code	Previous Home Phone (Area Code and No.)	
Previous Mailing Address	apt/fl	City, State, Zip Code	Previous Cell Phone (Area Code and No.)	
Previous Email Address		**NEW** Email Address		

REQUEST FOR REPLACEMENT ID CARD(S)
Please provide the Client Identification Number (CIN) or Healthfirst Identification Number. (EX. AB00000C OR 9XXXXXXX1)

Member Name
CIN # or Healthfirst ID #
Date of Birth
Member Name
CIN # or Healthfirst ID #
Date of Birth
Member Name
CIN # or Healthfirst ID #
Date of Birth

Was this form easy to fill out? ❑ Yes ❑ No
If No, please explain why.

COMPLETE THIS SECTION TO CHANGE YOUR PRIMARY CARE PROVIDER (PCP).
You will receive a new MEMBER ID card.

Member Name
CIN # or Healthfirst ID #
NEW PCP Name
NEW PCP ID # (Optional):
NEW PCP Address
NEW PCP Phone #
Previous PCP Name
Previous PCP ID # (Optional):
Previous PCP Address
Previous PCP Phone #

NOTIFICATION OF NEWBORN(S)

Member Name	
CIN # or Healthfirst ID #	
Newborn PCP Name	
Newborn PCP ID # (Optional):	
Newborn PCP Address	
Newborn PCP Phone #	
Newborn Name	
Date of Birth	Gender
Newborn CIN #	
Newborn Name	
Date of Birth	Gender
Newborn CIN #	

HEAD OF HOUSEHOLD SIGNATURE

DATE SIGNED