

**Provider Request for Member Deletion
from Primary Care Provider (PCP) Assignment**

PCP Name: _____ Member Name: _____
PCP Phone No.: _____ Member ID No.: _____
Date: _____ Member Date of Birth: _____
Member Phone No.: _____

Reason for Request

- Excessive “no shows”
- Urgent or emergency care abuse

What were the dates and circumstances?

- Member not allowing PCP to manage care
- Unreasonable demands for referrals

Have you ever seen this member? Yes No

What are the specific circumstances?

- Medication abuse

What is the member doing to obtain more medication than necessary?

- Abusive or disruptive behavior
- Unsatisfactory doctor/patient relationship (explain below)
- Other

Please give specific circumstances:

Add additional comments here:

Mail request to: Attn: Customer Service
BlueChoice HealthPlan of South Carolina
P.O. Box 100148
Columbia, SC 29202-3148