TRANSFER REQUEST FORM

Date:_____
Member Name:_____
Member ID #:_____
Member Telephone #:_____

Dental Office Name:_____
Office Telephone #:_____

GEOGRAPHIC MANAGED CARE	COMMERCIAL MANAGED CARE	HEALTHY FAMILIES PROGRAM	LOS ANGELES PREPAID HEALTH PROGRAM
❑ GMC	❑ DHMO	❑ HFP	❑ LAPHP

Reason for Request: All Provider Transfer Requests will be processed by the Plan within 30 days from the date of receipt. All approved transfers will be result in the deletion of the Member from the next month's roster. Providers will be notified by the Plan, in writing, of any denied requests.

- ❑ Member is repeatedly verbally abusive to the provider, auxiliary or administrative staff or other Plan members.
- ❑ Member physically assaulted the provider or staff person or another member or threatened another individual with a weapon on provider's premises. In this instance, the provider shall file a police report and file charges against the member.
- ❑ Member was disruptive to the provider's office operations.
- ❑ Member has allowed the fraudulent use of his/her coverage under the Plan, which includes his/her allowance of others to use his/her membership card to receive services from Providers.
- ❑ Member has failed to follow prescribed treatment (including failure to keep established appointments). This shall not, in and of itself, be good cause for a request for Member reassignment unless the provider can demonstrate that, as a result of the failure, the Provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the Plan and the rate-setting assumptions.

Additional comments for transfer:_____

_____

PLEASE STATE THE MISSED APPOINTMENT DATES:_____

Dentist's Signature:_____ **Date:**_____

PLEASE MAIL REQUEST TO: ACCESS /PREMIER ACCESS, P.O. BOX 659005, SACRAMENTO, CA 95865-9005
ATTENTION: CUSTOMER SERVICE DEPARTMENT

FOR ACCESS DENTAL PLAN OFFICE USE ONLY:

Person Receiving Complaint:_____
Date of Action:_____
Action Taken:_____

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