



**PROSPECT
MEDICAL**

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REQUEST FOR TRANSFER/DISENROLLMENT OF MEMBER FROM PROVIDER

Fax this completed form and a copy of documentation (certified letters, medical records with notation of incident(s), counseling provided, etc.) to the Member from the provider to Quality Management: (714) 560-7336

Member Name: _____

Health Plan Name: _____ ID Number _____

Provider Name: _____ PCP Specialist

ACTIVITY REPORT DATE/TYPE

(i.e. Failure to pay co-payments totaling \$50, missed a total of 3 appointments within 12 consecutive month period without timely cancellation. Fraudulent and dangerous behavior may qualify for immediate dismissal from group.)

1st Incident Date _____

Description of Incident:

2nd Incident Date _____

Description of Incident:

3rd Incident Date _____

Description of Incident:

MEDICAL GROUP USE ONLY

Date report sent to Healthplan: _____ Contact Name: _____ Phone # _____

Call back from Healthplan: _____ Effective date of member Disenrollment: _____

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Prospect Nuestra Familia Medical Group . Pomona Valley Medical Group . Prospect Health Source . Prospect Latino Medical Group
Prospect Medical Group . Prospect Medical Group Corona . Prospect Medical Group Los Angeles . Prospect Medical Group Van Nuys
Prospect Northwest Orange County . Prospect Professional Care . Prospect Professional Care Montebello . Upland Medical Group