Primary Care Physician (PCP) Designation Form

Please complete the following form to designate a Primary Care Physician (PCP) for each member on your health plan. PCPs may be from a family or general practice, internal medicine, or pediatrics. If the physician is a member of a group practice, **you must name a specific physician (MD or DO) within the practice.** To locate participating providers, please visit our website at www.pchp.net.

You may return this form by mail to Piedmont Community Health Plan, 2316 Atherholt Road, Lynchburg, VA 24501 or email it to customer.service@pchp.net.

Subscriber's First Name	Subscriber's Last Name	Piedmont Member ID	
PCP Name	Practice Name (If Applicable)		
Medical Office / Practice Address	City	State	Zip Code
Spouse or Dependent First Name	Spouse or Dependent Last Name		
PCP Name	Practice Name (If Applicable)		
Medical Office / Practice Address	City	State	Zip Code
Dependent First Name	Dependent Last Name		
PCP Name	Practice Name (If Applicable)		
Medical Office / Practice Address	City	State	Zip Code
Dependent First Name	Dependent Last Name		
PCP Name	Practice Name (If Applicable)		
Medical Office / Practice Address	City	State	Zip Code
Dependent First Name	Dependent Last Name		
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