CONFIRMATION OF MAIN DOCTOR OR OTHER HEALTHCARE PROFESSIONAL FORM

1. CONFIRM ✔

By signing below I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is _____ [PROVNAME AND/OR MEDICALGROUP] .

[BENENAME]

_____ **Signature**

_____ **Print Name**

___ /__ /_____ **Date**

____-___-_____ **Medicare Beneficiary Identifier (MBI)**

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call Community Care Cooperative (C3) at 1-866-676-9226 (TTY: 711), 8 a. m. – 5 p.m., Monday – Friday to request a new form.

2. RETURN ✉

Return this form in the envelope that we provided.

You may also fax it to Community Care Cooperative at 857-284-1450.

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits.