New Provider Action Form - Fax Number: (405) 917-7374

For Contracted Capacity and/or Age Restriction Overrides Only

Check Appropriate Reason(s)
Capacity Override – _____
Age Override – _____

Date: _____

Provider Name: _____ **SoonerCare Provider #:** _____ **Provider Email:** _____

Providers: An action form is to be used only when a PCP is requesting a member override to their contracted capacity and/or because of member age restriction. It does not change the capacity or age restrictions to your PCP contract. Member enrollment changes for all other reasons must be initiated and completed by the member utilizing the SoonerCare Helpline (1-800-987-7767).

Please make sure your provider name and provider location code is correct. Fax this form when completed to (405) 917-7374. Incomplete action forms or requests other than capacity or age reasons will not beprocessed. If you would like to be notified if there are issues with your form, include youremail address above.

1. **Complete the form below. Be sure to include all information requested.**
2. **The member or member's parent or legal guardian, must sign this form. Provider cannot sign the form for the member.**
3. **Only a provider's office can fax this form.**

Please print legibly in black ink – Use another form for more than four (4) members requesting a PCP change:

	Member(s) SoonerCare ID number	Mbr. DOB (required) mm/dd/year	Member(s) Social Security Number
1.		/ /	- -
2.		/ /	- -
3.		/ /	- -
4.		/ /	- -

Member address: _____ **Apt. #** _____ **City** _____ **State** _____ **Zip** _____

Adult Member Signature _____ **Date** _____ **Phone number or message phone + area code (___)** _____ **-** _____

SoonerCare Helpline Use Only:

Date Received _____ **Completed by:** _____ **Reason not processed:** _____

For Member Services Use Only: Reason not processed: _____

Date Received: _____ **Date completed:** _____ **Completed by:** _____