Primary Care Provider (PCP) Selection Form

Please complete this form, and mail it to:
Molina Healthcare of New York, Inc. -
Attention to: Member Enrollment -
5232 Witz Drive -
North Syracuse, NY 13212-6501 -

Fax: (315) 234-5916 -

Please print clearly.

Member Name: _____
Member ID #: _____
Member Date of Birth: _____

Address: _____
City: _____
State: _____
Zip: _____

Phone number: (_____) _____

Please name the Primary Care Provider (PCP) you would prefer to see:
_____

Signature: _____ **Date:** _____

You can also select or change your PCP online:

1) Member Portal: https://member.molinahealthcare.com/
2) Provider Online Directory : https://providersearch.molinahealthcare.com

If you have questions, regarding this letter, call Member Services for this information at (800)223-7242 (TTY: 711), Monday – Friday, 8:00 a.m. to 6:00 p.m.

For Providers:
Once the member completes the form, please fax it to (315) 234-5916 (Attention: "Member Enrollment"). The member may also email this form at MHNYEnrollment@molinahealthcare.com