



CONFIRMATION OF MAIN SOURCE OF CARE OR OTHER HEALTHCARE PROFESSIONAL FORM

1. CONFIRM

By signing below, I am confirming that _____ is where I usually receive routine medical care. Provider Name - _____

Beneficiary Name (Printed)

Date of Birth

Signature

____/____/____
Date

Email Address _____

Mailing Address _____

Medicare Number _____ Social Security # _____

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 Pathways Health Partners at 800-632-6228 to request a new form.

2. RETURN

Return this form in the envelope that we provided. Or use our online form by browsing to <https://pathwayshp.com/2024php-va/> or scan the QR code below and sign up conveniently on your smartphone.



3. OPT-OUT

☐ I do not want to receive marketing activities, including voluntary alignment, at my home or at the place where I receive care.

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