

## **REASSIGNMENT OF PROVIDERS BY PATIENT REQUEST**

1. **PURPOSE:** As partners in the healthcare process, patients have the right to participate in decisions regarding their care, including the ongoing relationship with their healthcare provider. Requests for reassignment expressed by a patient or guardian must be carefully considered. Improvement of care represents the goal of reassignment.
2. **POLICY:** A patient or guardian may request to obtain care from an alternative provider. After careful review, if reassignment is not expected to improve quality of clinical care, the request may be disapproved. Alternative providers must be VHA regular staff or contracted CBOC employees.
3. **RESPONSIBILITY:** The Chief of Staff is responsible for implementation and adherence to this policy.
4. **PROCEDURE:**
  - a. Patients or guardians who indicate a desire to change providers will be asked to provide the information for or to complete a "Request for Change in Provider" form (attached). This form may be completed by the patient or guardian, or may be initiated at their request by Medical Center staff. Requests will be forwarded to the accountable Clinic Manager (or, in their absence, the Service Line Operations Manager), who will review the case and make a recommendation to the Service Line Director.
  - b. If the request is approved, a new provider will be assigned based on open provider panels or other criteria applied by the service line to facilitate access to care. Accommodation will be based on treatment need and alternative provider availability. The Customer Assistant (CA) for the appropriate clinic will make an appointment with the new provider and the patient will be contacted.
  - c. If the request is denied, the patient or guardian will be notified of the decision by letter from the director of the accountable service line. A copy of all correspondence will be maintained in the service line administrative files. All requests will be processed within 30 days of receipt.
  - d. If the patient or guardian indicates a desire to appeal a decision to deny the request for reassignment, this will be forwarded to the Chief of Staff for review and disposition. If the denial of reassignment is endorsed by the Chief of Staff, the patient or guardian will be notified by letter. Further appeal is available through the VISN 15 Clinical Appeals process.
5. **REFERENCES:** None.

6. **RECISSION:** HPM 589A4-359 dated January 4, 2007.

APPROVED:

*Sallie Houser-Hanfelder, FACHE*

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Director

DATE: 4/27/10

Keywords: Reassignment  
Provider  
Request

Attachment

**Request for a Change in Provider**

Please complete the items below and

- 1. Give this request to clinic staff
- or**
- 2. Mail to: Primary Care Service Line  
Harry S. Truman Memorial VA Hospital  
800 Hospital Drive  
Columbia MO 65201

Patient Name (Please **PRINT**): \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Who is your **current** provider: (Physician or Nurse Practitioner): \_\_\_\_\_

**REASON FOR REQUEST**

- 1. Desire for a change in the **location** of your care. (Please mark the reason below.)
  - To receive care at a **community clinic ("CBOC")** because it is closer to home.
  - To receive care at the **Columbia VA hospital** because you already receive other care there or because it provides more services.

- 2. Desire for a **different provider**. Please describe why you are requesting a different provider:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Signature of patient or family member*

\_\_\_\_\_  
*Date*

\*\*\*\*\*

**For office use only**

**APPROVE**     **DISAPPROVE**

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Clinic Manager

\_\_\_\_\_  
Date

\*\*\*\*\*

**Concur**                       **Do not concur**

\_\_\_\_\_  
Director, Primary Care Service Line

\_\_\_\_\_  
Date