Behavior Analysis:
Change of Provider Form

This form must accompany the new Prior Authorization Request Form when a recipient has a current and active PA# with another provider.

Recipient Information

Client Name:	Medicaid ID#:
Date of Birth:	Current PA Number (if known):

Previous Provider Information

Name:	Last Day of Services:

New Provider Information

Name:	Provider ID#:
Start Date of Service:	Provider Signature:

This notice is to inform you that I, _____
(Recipient's name)

have changed providers effective: _____
(Date)

I am changing from provider: _____
(Provider's name)

to provider: _____
(New provider's name)

The following services will be affected by this change:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____
Recipient's Signature or (Guardian if applicable)

_____
(Date)

Client's address: _____
(Address line 1)

_____
(Address line 2)

_____
(City, State and Zip Code)

Revision date: March 2018