COLORADO
Department of Health Care Policy & Financing

Colorado Medicaid
Change of Provider Form

This form must accompany the new Prior Authorization Request (PAR) Form when a client has a current and active PAR with another provider.

Client Information

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

Previous Provider Information

Name:	Last Day of Services:

New Provider Information

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

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

have changed providers effective: _____
(Date)

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

to provider: _____
(New provider's name)

The following services/equipment will be affected by this change:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
Client's Signature or (Guardian if client cannot sign) (Date)

Client's address: _____
(Address line 1)

_____
(Address line 2)

_____
(City, State and Zip Code)

Revision date: March 2015