



Request for Medical Provider Changes
“For kids in licensed care only”

Child's Info

First Name: _____ Last Name: _____

Social Security Number: _____ DOB: _____ Medicaid Number: _____

Provider's Info

Please check which plan you prefer for the child: **Straight Medicaid**
 Medipass

Current Medical Provider's Full Name: _____

Provider's Full Address: _____

Phone #: _____

Requested Medical Provider's Full Name: _____

Provider's Full Address: _____

Phone #: _____

Case Manager's Info

Unit: _____ Assigned DCM: _____

Name of person submitting the request: _____

Phone number of person submitting the request: _____ Date request was submitted: _____

If you have any questions, please email: Elaine Burdock at eburdock@cfepbc.org or call 352-2506

For Internal Use Only

Date Processed: _____

Effective Date: _____