



## 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)