Change of Provider Request Form

Behavioral Health Providers

Members may use this form to change their behavioral health provider for a service for themselves, their child or legal dependent. This form serves as an official provider change approval.

Instructions:

Providers: Fill out all fields in the table below, then submit your prior authorization request with a copy of this form attached. To find prior authorization forms, please visit Superior's Behavioral Health webpage.

Members: Sign and date the lines at the bottom of this form.

Member Information:	
Member Name:	Member Medicaid Number:
Previous Provider Information:	
Previous Provider Name (if unknown, please indicate reason):	
Preferred Provider Information:	
Date of Provider Change: _____/_____/_____	Preferred Provider NPI:
Preferred (Current) Provider Name:	Preferred Provider TIN:

I certify that as of the date listed above, I prefer to receive or to have my child/legal dependent receive services from my preferred provider. I also want to cancel any authorization for these services with the previous provider listed above.

_____ _____

Member or Legally Authorized Representative Signature Date