



Fax form to: 94, ) ) -685-0005

Change Facility Request Form Medical Benefit Only			
Submitter Name and Title			
Submitted by	Ordering Provider	Servicing Provider	Third Party
Phone Number			
Fax Number			
Member Information			
Member Name			
IN MCD Provider Recipient ID # (RID)			
Member Date of Birth			
Prior Authorization			
Original Prior Authorization #			
Original Approval Duration			
Drug Name and HCPCS Code			
Current Servicing Provider			
Current Provider Name			
NPI			
Tax ID			
Last Date of Service			
New Servicing Provider			
New Provider Name			
Address			
Phone Number			
Fax Number			
NPI			
Tax ID			
Date(s) of Service Requested			