REQUEST TO CHANGE LOCK-IN PROVIDER

SECTION 1: MEMBER INFORMATION		
Member Name:		
Date of birth:	Member ID:	Phone:
Current address:		
City:	State:	ZIP Code:
Current Provider:		
New Provider:		
Name:	Address:	City:
State:	ZIP Code:	
SECTION 2: CHANGE PHARMACY		
Current Pharmacy:		
New Pharmacy:		
Name:	Address:	City:
State:	ZIP Code:	
SECTION 3: CHANGE HOSPITAL		
Current Hospital:		
New Hospital:		
Name:	Address:	City:
State:	ZIP Code:	
Reason for Request: ☐ I've moved ☐ Provider moved ☐ Provider left practice ☐ Provider no longer wishes to serve me ☐ Office/Provider location is hard to get to ☐ Provider no longer with Humana - CareSource ☐ Personal preference	☐ Communication problems with Provider/office staff ☐ Hard time getting appointments ☐ Wait time in the office too long ☐ Provider/office staff is rude ☐ Poor quality of medical care ☐ I have a health reason for the change ☐ I have been denied access to needed medical service [907 KAR 1:677, Sec. 6(c)(2)(a) Medicaid recipient lock-in program].	

****Please Note**: YOU MAY REQUEST A CHANGE OF ANY PROVIDER ONLY ONE TIME DURING YOUR ENROLLMENT INTO THE LOCK-IN PROGRAM.

All requests to change provider can be mailed to:

Humana – CareSource
P.O. Box 1940
Dayton, Ohio 45401-1940

Faxed to: 1-877-603-5119

KY-MMED-222 KDMS Approved 8/22/2013