



Fax form to: **1-855-685-0005**

| 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 | | | |
| CareSource Member ID | | | |
| Member Date of Birth | | | |
| Prior Authorization | | | |
| Original Prior Authorization Number | | | |
| 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 | | | |

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-833-230-2101**.

NV-EXC-P-4446633