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 #	
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	