

NOTIFICATION OF CHANGE

ATTN:	DATE:
FAX: (208)	FROM AGENCY:
PARTICIPANT:	MID#:
AGENCY CONTACT:	
<input type="checkbox"/> PARTICIPANT IN NURSING FACILITY – DATE ENTERED:	
<input type="checkbox"/> PARTICIPANT HAS MOVED – DATE: NEW ADDRESS & PHONE #:	
<input type="checkbox"/> PARTICIPANT IN HOSPITAL – DATE:	
<input type="checkbox"/> PARTICIPANT DISCHARGED FROM HOSPITAL – DATE:	
<input type="checkbox"/> PARTICIPANT DECEASED – DATE:	
<input type="checkbox"/> PARTICIPANT IS NO LONGER RECEIVING SERVICES <ul style="list-style-type: none"> • DATE & REASON: • LAST DATE SERVICE WAS PROVIDED: 	
<input type="checkbox"/> OTHER:	
<input type="checkbox"/> MEDICAID RESPONSE IS REQUESTED. PLEASE CALL. RE:	
<input type="checkbox"/> CHANGE OF AGENCY <ul style="list-style-type: none"> • CURRENT AGENCY: • NEW AGENCY: • REASON FOR CHANGE: 	
<p>The Department will process your provider change requests received by the 25th of the month to become effective the first day of the following month. Requests received after the 25th will not be effective until the first day of the second month. Case by case exceptions for approvals during the month will be considered by the Department for instances of fraud or abuse by the caregiver. If the provider terminates your services, your new provider request will be processed by the Department throughout the month.</p>	
PARTICIPANT'S SIGNATURE	DATE