

**PATIENT/CAREGIVER REQUEST TO CHANGE PROVIDER
TO MEDICAL RESOURCES, INC.**

Patient Insurance/Demographics Information:

Patient Name: _____ Patient D.O.B ____ / ____ / ____
Caregiver Name (s): _____ Telephone (s): (____) _____
Patient Address: _____ City: _____ State: _____ Zip: _____
Attending Physician: _____ Ordering Physician: _____
Primary Insurance: _____ Policy #: _____ Group #: _____
Secondary Insurance: _____ Policy #: _____ Group #: _____

Current (as of the date of this request) Medical Equipment Provider information:

Name of Current Medical Equipment Provider: _____ Telephone: (____) _____
Representative Name: _____ Fax Number: (____) _____

Patient/caregiver hereby requests Medical Resources to provide items/services listed.
Patient/caregiver requests current medical equipment provider to respect patient/caregiver right to choose medical equipment provider, as exercised by signature below, without coercion or attempt to dissuade this decision, and hereby exercises this right by this request to choose another medical equipment provider to provide equipment/services listed.

Medical Resources' consideration to provide under assignment from Primary or Secondary Payer relies on receipt of accurate information from current medical equipment provider, including but not limited to, physician prescription/medical necessity documentation, and discontinuation/expiration of current provider's current equipment/billing cycles for items listed. Other terms and conditions apply and are described during, or prior to, time of delivery.

Patient caregiver hereby requests current medical equipment provider to promote and support this decision by providing Medical Resources with copies, within 7 days of date authorized below, of Physician Orders, Medicaid 360, EPSDT, Prior Authorizations, CMNs, Medical Necessity Documents, Prior Authorizations, and Billing Begin/End dates.

Patient caregiver requests current medical equipment provider to decrease possibility of interruption in services by temporary continued provision of equipment/services, only until future date and time of verbal patient caregiver request to cease and stop.

Medical Resources receipt of faxes/emails should be confirmed at, and communications may be made directly to, telephone number:

(telephone) 205 521 7337 ext 226 or (fax) 205 521 0585 or (email) wecare@mdr.net

Item(s) Description(s)/# months patient has received item(s): _____

Patient/Caregiver Signature: _____ Date: _____