STATE OF OKLAHOMA
Oklahoma Health Care Authority

Change of Provider

Prior Authorization Form

Member Name: _____
Member RID #: _____
Service being Rendered _____

I _____ (print name of member/parent/legal guardian)
hereby wish to change the above listed services being provided by
_____ (print name of previous provider) **to**
_____ (print name of New provider) **effective**
_____ (date the change is to take place)**.**

_____
Signature of Member or Parent/Legal Guardian if a minor

_____
Date Signed by Member/Parent/Legal Guardian

_____
Relationship to Member

******Please Note: Form must be completed in its entirety or will be considered incomplete and will not be accepted******