CHANGE OF PROVIDER FOR MEDICAL SUPPLIES

Insurance: ___________________________________ **ID Number**: ___________________

Patient Name: ___________________________________

I ___________________________________, on behalf of myself or my Authorized Representation of patient,

request that authorization for medical supplies be given to **MAXWELL MEDICAL SERVICES**. I am transferring

services from ___________________________________ and services were last received on

___________________________________. Please terminate the Prior Authorization

Number given to this Company effective ___________________________________ for the

following needed medical supplies:

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

By signing this form, I ___________________________________ acknowledge that **MAXWELL MEDICAL SERVICES** will be my new provider of medical supplies. I will be contacted on a monthly basis as an inquiry to see if I need to reorder my supplies, unless other arrangements have been made. Information has been provided to me in regard to how I can refill my supplies and make requests or adjustments to my order if needed.

___________________________________ _____________________

Signature Date

___________________________________ ___________________________________

Relationship to Patient (if applicable) Reason Patient Unable to Sign (if applicable)

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