



CHANGE IN RSPMI PRIMARY PROVIDER

Beneficiary Name (print) _____

Beneficiary Medicaid number _____

Parent/Guardian Name (print) _____

Parent/Guardian Address _____

Parent/Guardian Daytime Phone Number (Include cell phone)

Day # _____ Cell# _____

I choose to change RSPMI mental health Primary Provider:

FROM: _____
(Name of current RSPMI Primary Provider)

TO: _____
(Name of newly chosen RSPMI Primary Provider)

In making this choice I understand that my current RSPMI Primary Provider will no longer be authorized to provide me mental health services except to the extent, these future services may be authorized by newly chosen RSPMI Primary Provider.

Guardian/Client Signature Date: _____

Witness Signature Date _____