

**REQUEST TO CHANGE PROVIDER LOG**

This log is to be maintained by Program Manager for the program(s) he/she is responsible. A completed entry shall be made for each Request for Change of Provider Form received during the month. A copy of the Request to Change Provider Log shall be sent to the Patients' Rights Office - Beneficiary Services Program by the tenth (10<sup>th</sup>) working day following the month for which the log is completed.

Month \_\_\_\_\_ Year \_\_\_\_\_

Check if no requests were received during this month

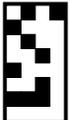
DATE RECEIVED	DATE OF REQUEST	BENEFICIARY NAME	CURRENT PROVIDER	NEW PROVIDER	REASON FOR REQUEST (If beneficiary willing to state)	REASON REQUEST NOT GRANTED

Reporting Unit \_\_\_\_\_

Program Manager \_\_\_\_\_

Date \_\_\_\_\_

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This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled

Name

\_\_\_\_\_

IBHIS/IS #

\_\_\_\_\_

Family Practitioner

\_\_\_\_\_