COLORADO
Department of Health Care Policy & Financing

Health First Colorado Change of Provider Form

This form must accompany the new Prior Authorization Request (PAR) Form when a member has a current and active PAR with another provider.

Member Information

Member Name:	Health First Colorado ID#:
Date of Birth:	Current PAR Number (if known):

Previous Provider Information

Name:	Last Day of Services:

New Provider Information

Name:	Provider ID#:
Member Start Date of Service:	Provider Signature:

This notice is to inform you that I, _____
(Member's name)

have changed providers effective: _____
(Date)

I am changing from provider: _____
(Provider's name)

to provider: _____
(New provider's name)

The following services/equipment will be affected by this change:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
Member's Signature (or Guardian if member cannot sign) **(Date)**

Member's address: _____
(Address)

_____
(City, State, Zip Code)

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