



**Change of Dental Provider Request**

Fax to: 405-530-7178

Please allow 7-10 business days for request to be processed

Prior Authorization # \_\_\_\_\_

Member Name \_\_\_\_\_

Member ID # \_\_\_\_\_

Requested by:

Patient/Parent signature & phone: \_\_\_\_\_

Doctor/Office signature: \_\_\_\_\_

**REQUESTED CHANGE:**

Group/Pay to Provider #  
Change SoonerCare ID # to \_\_\_\_\_

Rendering Provider #  
Change SoonerCare ID # to \_\_\_\_\_

Reason for Change: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Person \_\_\_\_\_

Contact Phone/Fax Number \_\_\_\_\_

Date \_\_\_\_\_