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 _____