



Date: _____

To: The Medicaid Department -- State of Texas

Re: Change of Providers for Medical Supplies

I, _____, am requesting that the authorization for my medical supplies be given to Star Medical. The patient, _____, and their Medicaid ID number is _____ . Please change the Prior Authorization Number from company, _____, for my medical supplies as follows effective as of the date on this letter.

Supply List:

Thank you for your prompt attention to my request.

Signature of Patient/Guardian: _____