PROVIDER CHANGE REQUEST FORM

INSTRUCTIONS:
Please allow up to 30 days to receive a response. Forward your completed form to LifeWays Customer Service. Mail or drop off: 1200 N. West Ave. Jackson, MI 49202 or 25 Care Dr. Hillsdale, MI 49242
Email: customerservice@lifewayscmh.org Fax: (517) 789-9068

CONSUMER'S NAME:	CONSUMER'S DATE OF BIRTH:
ADDRESS:	PHONE:
PERSON COMPLETING THIS FORM (if not consumer):	EMAIL (if applicable):

PROVIDER YOU WOULD LIKE TO CHANGE FROM: ______________________

REASON FOR REQUESTING A CHANGE OF PROVIDER:

☐ My provider does not offer appointments on the days or times I need. *Please describe the schedule accommodations you need: ______________________

☐ Medication issue

☐ I am unhappy with my provider

☐ Other: ______________________

Additional comments: ______________________

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I understand that my request will be reviewed and that a change in provider is not guaranteed.

______________________ ______________

SIGNATURE OF PERSON COMPLETING FORM DATE

FOR OFFICE USE ONLY

Request ☐ APPROVED ☐ DENIED ☐ PROCESS AS A GRIEVANCE

New provider (if approved): ______________________

Date supervisor spoke with consumer (if denied): ______________________

Comments: ______________________

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SUPERVISOR'S SIGNATURE DATE