



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 Specialties.

The patient, _____, and their Medical 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: _____