

REQUEST TO CHANGE LOCK-IN PHARMACY

One pharmacy change allowed in a six-month period (unless good cause)

Recipient Name: _____

Recipient Medicaid Number: _____

Recipient Address: _____

Recipient City, State Zip: _____ Recipient Phone Number: _____

I want to change my “Lock-In” Pharmacy to the following:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy City, State Zip: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Pharmacy License Number: _____

Pharmacy Medicaid Provider Number: _____

Please make this change effective as of mm/dd/yyyy: ____/____/____

Recipient Signature _____ Medicaid ID: _____

Fax completed form to: 1-866-351-7388 or mail to the address below:

Sunshine Health
Attn: Pharmacy Department
1301 International Pkwy Suite 400
Sunrise, FL 33323