



## Behavior Analysis (BA) Member Plan Change Form

This form must be completed whenever a member changes health plans and is assigned a new policy number.

Complete and **Fax** to: 1-844-208-9113

### Required Documentation to Submit Request

- Fax cover sheet with member and provider point-of-contact information.
- Proof of prior authorization/notice of coverage.
- Written statement explaining plan change (e.g., "Member transitioned from Plan A to Plan B").
- Include the old policy end date and the new policy start date.

**Note:** All fields must be filled in as incomplete forms will be rejected.

### MEMBER INFORMATION

Date of Birth: \_\_\_\_\_ Medicaid/Member ID: \_\_\_\_\_

Last Name, First Name: \_\_\_\_\_

### REQUESTING PROVIDER INFORMATION

Agency Name: \_\_\_\_\_

Group National Provider Identifier (NPI): \_\_\_\_\_

Taxpayer Identification Number (TIN): \_\_\_\_\_

Servicing Practitioner Name: \_\_\_\_\_

Servicing Practitioner Name NPI: \_\_\_\_\_

Provider Fax Number: \_\_\_\_\_



**PREVIOUS AUTHORIZATION INFORMATION**

Agency Name: \_\_\_\_\_

Group National Provider Identifier (NPI): \_\_\_\_\_

Taxpayer Identification Number (TIN): \_\_\_\_\_

Servicing Practitioner Name: \_\_\_\_\_

Authorization Number (from Sunshine Health if applicable): \_\_\_\_\_

CPT Code(s): \_\_\_\_\_

Authorized Units: \_\_\_\_\_

Approved Date of Service (DOS) Span: \_\_\_\_\_

**PREVIOUS HEALTH PLAN INFORMATION**

Policy Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Start Date: \_\_\_\_\_ Policy End Date: \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

**NEW/CURRENT HEALTH PLAN INFORMATION**

Policy Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Start Date: \_\_\_\_\_ Policy End Date: \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

**IMPORTANT:** Standard Continuity of Care (CoC) guidelines apply. If your authorization request includes dates of service beyond the standard COC period, clinical documentation will be required. After the COC period ends, all requests will be reviewed for Medical Necessity (MNC).

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.  
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