LifeWays

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@lifewaysmi.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:

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:

______________________________ ______________

SUPERVISOR'S SIGNATURE DATE