Request to
Change BCMH Managing Physician

To: Children with Medical Handicaps Program (BCMH)

From: _____
(Parent or Legal Guardian's Name)

Regarding: _____
(Child/Client's Name)

BCMH #: _____

County: _____

Please inform BCMH regarding the change in managing physician by completing this form and sending it to: **Children with Medical Handicaps Program**
P.O. Box 1603
Columbus, Ohio 43216-1603

☐ Child no longer sees Dr. _____
(Physician's First and Last Name)

☐ I wish to change child/client's managing physician to Dr. _____
(Physician's First and Last Name)

Note: Physician must be a provider on the BCMH program and a provider within your primary insurance network.

☐ Appointment has been scheduled with Dr. _____ on _____
(Date)

☐ BCMH services are no longer needed.

Required Signature: _____
(Parent/legal guardian or client if 18 years old or older) (Date)

Address: _____

_____

_____

Phone: ( ) _____