



**Department of Human Services
Division of Medical Assistance Programs**

Request to Change Pharmacy

Client Name _____

Medicaid ID Number _____

Current Enrolled Pharmacy _____

Requested New Pharmacy:

Name _____

Address _____

Provider Number, if known _____

**I understand this pharmacy change will apply to all eligible persons on my case.
I understand this change may take up to three days to process.**

Client Signature _____

Date _____

**FAX TO:
DMAP Client Advisory Services Unit
503-945-6898**