121 Interpark Blvd, Ste 300
San Antonio, Texas 78216
210-593- WAVE (9283) Office
866-492-7762 Fax

CHANGE OF DME PROVIDER LETTER

Date: _____

Patient Name: _____ DOB:_____

Medicaid #: _____ Diagnosis: _____

Address: _____

To Whom It May Concern:

Effective_____, I would like to change my child's current Medicaid DME Provider(s)
(Transfer Date)

from_____to Wave Healthcare. This will allow Wave
(Name of DME Provider)

Healthcare to request authorization for DME services on your behalf. The equipment and/or

supplies I would like transferred are:

_____
_____
_____

Reason for leaving other DME company (ies):

_____
_____

Thank you,
Parent/Guardian Signature: _____ Date: _____