121 Interpark Blvd, Ste 300 San
Antonio, Texas 78216

Office: 210-593-WAVE (9283)

Fax: 210-593-9284

# 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 Medicaid DME Provider(s)
(Transfer Date)

from __________________________________ to Wave Healthcare.
(Name of current DME Provider)

The equipment and/or supplies I would like transferred are:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Reason for selecting Wave Healthcare as DME provider:

________________________________________________________________________________

________________________________________________________________________________

Thank you,
Parent/Guardian Signature: ________________________________________ Date: ____________