Health Coverage Eligibility and Plan Change Form

Fax Number: (877) 556-5873

Clinic Name: Child and Adolescent Clinic

Physician Name: _____

Molina Healthcare Contact: _____

Please choose one:

☐ I want to *apply for free or low cost health care coverage for myself or my child.*		
Name	**Address**	
City	**Zip**	**Phone***

☒ I want to change our current health plan to Molina Healthcare of Washington.			
ProviderOne ID#	**Name**	**Date of Birth**	**Relationship**
Phone*		**Zip Code**	
Signature _____			

A plan representative may call.

For more information, call Molina Healthcare at (800) 294-8620.

MRC Part #11-906
Approvals: MHW – 12/27/11 HCA – 1/20/12