



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:

<input type="checkbox"/> I want to <i>apply for free or low cost health care coverage for myself or my child.</i>		
Name		Address
City	Zip	Phone*

<input checked="" type="checkbox"/> 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

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