3100 HIGHLAND AVENUE
CANON CITY, CO 81212
1-800-800-5914 ~ FAX 1-719-276-1708

MEDICAID/MEDICARE

TO WHOM IT MAY CONCERN:

Please be advised as of this date ______________________,

Name _____________________________, date of birth_____________________

Medicaid # ______________________________

Medicare # ______________________________

I am requesting that E.A.S.E. Medical Supply, Inc, be my Medicaid/Medicare supply provider. Please note this change to my records.

Thank you,

____
Client's or Authorized Persons signature (ELECTRONIC)

____
Relationship to Client

Form Date: 03/05 **Electronic Form Date: 07/07**