Ohio Living Home Health & Hospice	Patient Name	
	Address	
	City	State
	ZIP	DOB
	Phone	Fax

Change in Designation of Attending Physician

I am requesting a change in the designation of my attending physician. I understand I have the right to choose my attending physician. The physician named below is my attending physician of choice and will replace my current attending physician.

Full Name of Attending Physician:			NPI Number:
Office Address:	City	State	Zip Code

The above named physician will replace my current physician.

Full Name of Current Attending Physician:	
Effective Date of Change of Attending Physician: (Effective date of change can be no earlier than the date the form is signed.)	Date:
Patient's Signature:	Date:
Representative's Signature	Date:
Witness Signature:	Date:
If patient is unable to sign, state reason:	□ medically unable □ other _____