Change of Vendor Request Form

Type of Benefit: _______________________________________

Your signature on this document acknowledges you:

- Agree to inform your current vendor of the vendor change.
- Medical/surgical clients are aware the change of vendor will start on the next AADL two month benefit period (vendor changes are effective on the first day of January, March, May, July, September and November.)
  
  **NOTE - Medical/Surgical clients:** Continue to purchase all diapers, pads, liners, catheters, and ostomy supplies from your current vendor until the vendor change is completed.
  
  **NOTE - Mobility clients:** A change of vendor can only be done if you have not received the equipment or have arranged with AADL to refund your current vendor.
  
  **NOTE – Clients with authorizations for compression garments may change vendors at any time while their authorization is active.

Please complete the following information and mail or fax to AADL:

I authorize AADL to change my vendor from

<table>
<thead>
<tr>
<th>Name of Current Vendor</th>
<th>to</th>
<th>Name of New Vendor</th>
</tr>
</thead>
</table>

My Authorization Number is: _____________ (contact your current vendor or authorizer if unknown).

Your new vendor will need this number in order to provide your AADL benefits.

My new vendor number is ______________________________ Vendor will provide).

AADL Client Information

_________________________ -

Name (Please Print) Personal Health Care Number

If AADL has any questions or concerns I can be reached at ________________________

 Telephone number with area code

Consent

You or your legal representative (e.g. person with your power of attorney, a guardian/trustee) must sign and date this form.

_________________________ X ________________________

 Print Name (Yours or Legal Signature (Yours or Legal
 Representative’s) Representative’s) Date (YYYY/MM/DD)