HYGEIA
Medical Supplies and Services

Switch of Provider Form

Date: _____

By signing this form, I _____, declare to switch my current DME provider from _____ to Hygeia Medical Supplies and Services, Inc. I understand that this is my choice and I have made the decision to discontinue my services from my existing DME provider. Therefore, I authorize the release of any medical information needed to process and finalize this switch to Hygeia Medical Supplies and Services, Inc.

Beneficiary Signature: _____

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