Driscoll Health Plan
News and Updates

Date:

Jan-26

2026

Contact Information

For questions or additional assistance, contact:

Provider Relations
956-632-8308

To enter authorization requests and upload clinical via the Provider Portal, visit driscollhealthplan.com/providers

To verify authorization requirements via the Authorization Requirement Portal, visit driscollhealthplan.com/priorauthcheck

To submit authorization requests or clinical to the UM Dept. via fax, send to 1-866-741-5650

Attention: Change of Provider Requests

Per the TMPPM, a member has the right to choose their service provider and to change providers at any time.

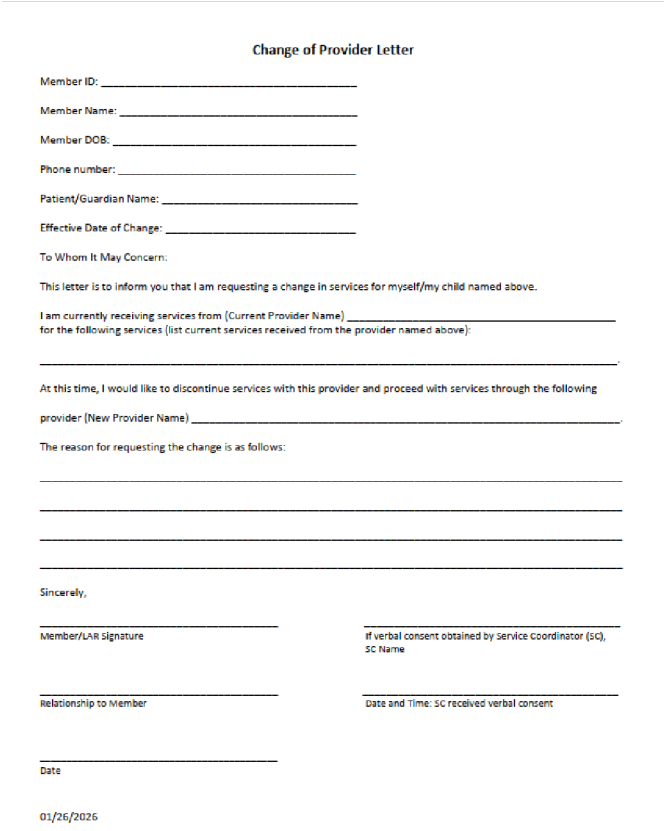
If a member wishes to change providers for any service they are currently receiving (mid-authorization), DHP must receive a Change of Provider letter along with either a new Texas Standard Prior Authorization Request Form (TARF) and/or a new Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form from the ordering provider.

The Change of Provider letter must be signed and dated by the member or their legally authorized representative (LAR) and must include:

- The name of the previous provider
- The name of the new provider
- The effective date of the provider change

A sample Change of Provider letter template is available for reference on the DHP Authorization Requirement website:

https://driscollhealthplan.com/priorauthcheck/forms-and-checklists/



Change of Provider Letter

Member ID: _____

Member Name: _____

Member DOB: _____

Phone number: _____

Patient/Guardian Name: _____

Effective Date of Change: _____

To Whom It May Concern:

This letter is to inform you that I am requesting a change in services for myself/my child named above.

I am currently receiving services from (Current Provider Name) _____
for the following services (list current services received from the provider named above):

_____.

At this time, I would like to discontinue services with this provider and proceed with services through the following

provider (New Provider Name) _____.

The reason for requesting the change is as follows:

_____

_____

_____

_____

Sincerely,

_____ _____

Member/LAR Signature

If verbal consent obtained by Service Coordinator (SC), SC Name

_____ _____

Relationship to Member

Date and Time: SC received verbal consent

_____

Date

01/26/2026

* To access the DHP provider portal , visit driscollhealthplan.com