TEXAS Health and Human Services

Form H1107
April 2005

Request for Forced Change of Medical Coverage

TO: **SDX/Medical Eligibility Unit**
Data Integrity Section
State Office 952-X

FROM: _____

_____
Address Mail Code

Case No.	Case Name	Category	Type Program

Client No.	**Client Name**	**Requested Medical Coverage**		**File Date for Requested Med.**
		Begin Date	**End Date**	

Reason(s) for Request:

- ☐ Hearing Officer Decision (Attach copy of Form H4807, Official Record of Fair Hearing.)
- ☐ Three Months Prior Was Not Processed with Application for Ongoing Benefits
- ☐ Initial Coverage Was Not Provided from the Application Month
- ☐ Other (explain):

_____ _____
Signature – Worker Date

Worker Name (please print or type)	BJN	Telephone No. (inc. A/C or STS)

Data Integrity Response

Medical coverage was provided as requested on ..... _____
Date

Please advise providers to resubmit claims marked "delayed billing" and to indicate the date coverage was added to the file.

Comments: _____

_____ _____
Signature – Data Integrity Staff Date

Send original and one copy to Data Integrity; one copy to file.