

Letter of PA Reinstatement

Client Name: _____

Client Sooner Care or Insure Oklahoma ID #: _____

I, _____, wish to discontinue receiving services with any other
(Client's name)

Provider/Agency and reinstate my services with _____ as of
(Provider/Agency name)

(MM/DD/YY)

Please state reason for reinstatement (to be completed by client/guardian).

Member (14 and over must sign)

Date Signed

Legal Guardian

Date Signed