MONTANA
Department of Public Health & Human Services

Montana Marijuana Program
CHANGE REQUEST FORM

Registered cardholders (patients) and providers/MIPPS must use this form to submit any information changes to the department.

REVIEW THE CHECKLIST BELOW BEFORE SUBMITTING THIS FORM TO THE DEPARTMENT

→ Mail this completed form to DPHHS/MMP, PO Box 202953, Helena, MT 59620-2953
→ There is no fee for submitting a change request
→ More than one change can be made on a single form
→ If a patient is adding or changing provider/MIPP, the patient ***and*** new provider/MIPP must sign form.
→ Provider information will only be changed if the *provider* submits a change request form. Provider information will not be changed if the change request form is for a registered cardholder.

☐ Add Provider ☐ Change Provider ☐ Remove Provider ☐ Remove Patient

☐ Name Change (requires legal documentation) ☐ Street address Change

☐ Mailing address change ☐ Registered premises (grow location) address change*

☐ Other, Specify____

*If you will be cultivating and/or manufacturing marijuana at an address that is rented or leased, you must include a LANDLORD PERMISSION FORM with this change request.

REGISTERED CARDHOLDER (PATIENT) INFORMATION

COMPLETE THIS SECTION IF THE REGISTERED CARDHOLDER IS CHANGING PERSONAL INFORMATION OR ADDING OR REMOVING A PROVIDER

Current card number: ________________Expiration date: _______________

Legal Name (Last): ___________________________ (First): _____________________________ MI: ______

Social Security Number: __________________________Phone Number:_________________________________

Montana Driver's License number or State of Montana issued ID number: ______________________________

Mailing Address: _______________________________ City: ____________________ Zip Code: ____________

Street Address: ________________________________ City: ____________________Zip Code: ____________

Registered Premises Address: ____

City: ________________ Zip Code: _____________

____ _______________________

Signature of registered cardholder Date

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PROVIDER/MIPP INFORMATION

COMPLETE THIS SECTION IF THE REGISTERED CARDHOLDER IS CHANGING OR ADDING PROVIDER/MIPP OR PROVIDER/MIPP IS CHANGING PERSONAL INFORMATION OR REMOVING A PATIENT

Current Provider/MIPP ID: ____________________ Date of Birth: ____________________

Legal Name (Last): ____________________________ (First): ______________________________ MI: ______

Social Security Number: ___________________________Phone Number: ________________________________

Montana Driver's License number or State of Montana issued ID number: ______________________________

Mailing Address: _____________________________________ City: ________________ Zip Code: ____________

Street Address: ____________________________________ City: ___________________Zip Code: ____________

Registered Premises Address: ____

City: _________________ Zip Code: ______________

____ ____________________________

Signature of provider/MIPP Date

If registered cardholder (patient) is requesting a provider/MIPP that is not a currently registered with the department, the department will send the individual a provider/MIPP application packet.