DME change of vendor request form

Please fax form and claim information to 503-416-3637
Your request should include DME Prior Authorization Form and supporting documentation.

Person completing the form

Name: _____ Vendor name: _____

Date: _____ Phone#: _____ Fax#: _____

Member name

Last name: _____ First name: _____ MI: _____

DOB: _____ Subscriber ID#: _____

Vendor information

Vendor want to change **from**: _____

Vendor want to change **to** (include TIN): _____

Equipment/Supplies involved (include HCPC/billing codes and quantity):

_____

Reason for changing:

_____

PLEASE NOTE: CareOregon's policy is that vendor changes will be allowed up to one (1) time per year UNLESS member has moved or there is evidence that a unique situation exists that would allow for a policy exception to be made.