CHANGE OF VENDOR REQUEST FORM
Revised January 2014
FAX TO: 503-416-3637

1. PERSON COMPLETING THE FORM:

   Date: ___/___/_____ Name: _____Vendor Name: _____

   Telephone #: _____ Fax #: _____

2. MEMBER NAME: _____/ _____/ _____
   Last First MI

   DOB: ____/___/_____ Subscriber ID #:_____

3. VENDOR INFORMATION:

   Vendor Want to Change **From**: _____

   Vendor Want to Change To: _____

   Equipment/Supplies Involved: _____

   _____

   _____

   _____

   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.