DME Change of Vendor Request Form

Please fax form and claim information to 503-416-3637

CareOregon

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**: _____

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.