



DMEPOS - HH - EPIV Prior Authorization Form – Revised January 2010
For ALL Faxes: 503-416-3637 or Toll Free: 1-800-862-4831

Date: ___/___/___ Provider (Agency/Vendor) Name: _____ Tax ID #: _____

Contact Person _____ Phone # _____ Fax # _____

Member Name: _____ DOB: ___/___/___ DMAP ID# _____ COA OHP Plus OHP Std

Address: _____ City: _____ Zip Code: _____ Phone # _____

Prescribing Provider Name: _____ Telephone #: _____

Primary ICD-9 _____ Description _____; ICD-9 _____ Description _____

Comments: _____

(Record applicable HCPCS and appropriate modifier, CPT, or Revenue): *Dates of Service: From _____ To _____* DMEPOS HH EPIV

Code _____ Modifier _____ Description _____ Quantity _____ @ Price \$ _____ = Total \$ _____

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PLEASE NOTE: DMEPOS staff is NOT authorizing the above quoted prices! Payment is based on contracted rules unless otherwise indicated.