



**DMEPOS - HH - EPIV Prior Authorization Form – Revised January 2011**  
**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  
Last First

Prescribing Provider Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Last First

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

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**\*PLEASE NOTE: DMEPOS staff is not authorizing the quoted price or total! Payment is based on contracted rules unless otherwise indicated.**