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: ____

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Reason for Changing: ____

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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.