

**DMEPOS - HH - EPIV Prior
Authorization Form
For OHMS providers only**



Fax this completed form to 541-956-5460.

Date ____ / ____ / ____ Provider (Agency/Vendor) Name _____

Tax ID # _____

Contact Person _____ Phone _____ Fax _____

Member Name _____ DOB ____ / ____ / ____ DMAP ID# _____

Address _____ City _____ Zip Code _____ Phone _____

Prescribing Provider Name _____ Telephone _____

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

Record appropriate HCPCS and modifier, CPT or revenue Service dates from _____ to _____ DMEPOS HH EPIV

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

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Comments _____

**DMEPOS staff does not authorize the quoted price. Payment for authorized services
is based on contracted rates unless otherwise indicated.**

Authorized _____ Auth # _____ Effective Date ____ / ____ / ____ through Date ____ / ____ / ____

Comments _____

Signature _____ Date ____ / ____ / ____ Denied _____ Letter completed _____