



**DMEPOS - Prior Authorization Form – Revised December 2018**  
**For ALL Faxes: 503-416-3637 or Toll Free: 1-833-205-3632**  
**\*\*Effective 1/1/19, Home Infusion requests should be submitted via our provider portal, CareOregon Connect or on the HOME INFUSION request form.**  
**Enteral or Parenteral requests should be requested on the ENTERAL/PARENTERAL NUTRITION request form\*\***

Date: \_\_\_/\_\_\_/\_\_\_ Provider (Agency/Vendor) Name: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Member Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Subscriber ID# \_\_\_\_\_  
Last First

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

Primary Dx Code \_\_\_\_\_ Description \_\_\_\_\_; Dx Code \_\_\_\_\_ Description \_\_\_\_\_

Comments: \_\_\_\_\_

(Record applicable HCPCS and appropriate modifier, CPT, or Revenue): **Dates of Service:** From \_\_\_-\_\_\_-\_\_\_ To \_\_\_-\_\_\_-\_\_\_

**\* PDAC verification is required for OHP requests for codes K0108 and E1399 >\$150 per OAR**

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 \$ _____

\*as listed on fee schedule \*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.**