

DME Change of Vendor Request Form

Please fax form and claim information to 503-416-3637



Person Completing the Form

Name: _____ Vendor Name: _____

Date: _____ Phone#: _____ Fax#: _____

Member Name

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Subscriber ID#: _____

Vendor Information

Vendor Want to Change **From**: _____

Vendor Want to Change **To**: _____

Equipment/Supplies Involved: _____

Reason for Changing: _____

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.