Enteral/Parenteral Nutrition 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 out provider portal, CareOregon Connect or on the HOME INFUSION request form.**
DME requests should be requested on the DMEPOS request form**

Date: ____/____/____ Provider (Agency/Vendor) Name: ______________________________ Tax ID #: ____________________

Contact Person ______________________________ Phone #____________________ Fax #____________________

Member Name: ____________________ (Last) ____________________ (First) DOB: _____/_____/______ Subscriber ID# ____________________

Prescribing Provider Name: ____________________ (Last) ____________________ (First) Telephone #: ____________________ Fax#: ____________________

Primary Dx Code___________Description______________________________; Dx Code__________Description______________________________

Comments: ____

(Record applicable HCPCS and appropriate modifier, CPT, or Revenue): **Dates of Service:** ***From***________ ***To***_________ **Parenteral** **Enteral**

∗as listed on fee schedule

Code__________ Modifier _____Description______________________________ Quantity _______@ ***Price $*** ________= ****Total $***__________

Code__________ Modifier _____Description______________________________ Quantity _______@ ***Price $*** ________= ****Total $***__________

Code__________ Modifier _____Description______________________________ Quantity _______@ ***Price $*** ________= ****Total $***__________

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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.