



**DME REFERRAL FORM  
OHP (COIHS)**

- THIS FORM IS TO BE USED FOR COIHS DURABLE MEDICAL EQUIPMENT REFERRAL REQUESTS.
- PLEASE COMPLETE IN FULL.
- PLEASE PRINT LEGIBLY.
- **PLEASE FAX REQUESTS TO: 541-382-2952 OR TOLL FREE AT 877-709-6708**

DME PROVIDER NAME:	
PHONE #	FAX #:
COIHS AUTHORIZATION REQUEST: <input type="checkbox"/> NEW <input type="checkbox"/> RENEWAL	
MEMBER NAME:	
ID#:	

DIAGNOSIS:	MD:
LENGTH OF NEED:	OXYGEN SAT: %

HCCP	DESCRIPTION OF DME EQUIPMENT/SUPPLIES	QTY/PRICE		PURCH/RENT

COMMENTS: PLEASE START AUTH ON \_\_\_\_\_ BASED ON ATTACHED CVO.

SUPPORTING DOCUMENTATION:  CVO  RX  CHART NOTES  LMN

**NOTE:**

**THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.**

Claims payment will be based on member eligibility, medical necessity and OHP benefits in effect at the time of service.