Frontier Medical

P.O. Box 1027, Bountiful, UT, 84010
Office, (801) 979-4638
Fax, (801) 807-0144
orders@ftmed.net

DME Provider Change Request Form

Attn: DOL Medical Benefits Examiner (DEEOIC)
OWCP/DFEC
PO Box 8300
London, KY
40742-8300

Re: DME Provider Change Request

DEEOIC Claimant Name (printed): _____

Case ID #: _____

Date of Birth: _____ (mm/dd/yyyy)

Claimant's Telephone #: _____

Claimant's Email: _____

I am requesting a change in my Durable Medical Equipment (DME) Provider – from _____ (current provider), to Frontier Medical, LLC (Provider #: 62025400), effective _____ (mm/dd/yyyy).

Thank you for your time, please let me know if additional documentation is needed.

Claimant Signature: