



EDMS COVERSHEET



Use to fax documents for entry into the Oregon Medicaid Electronic Document Management System (EDMS).

From: _____

Date: _____

Phone: _____

No. of Pages: _____
(including this coversheet)

Document Type: Check only one box and fax to the number shown. Use a new coversheet for each transaction.

Provider Enrollment (PE) - 503-378-3074

Hearing Documentation (no central fax #)

Claim Documentation - 503-378-3086

Grievance Documentation (no central fax #)

Prior Authorization (PA)

Correspondence - 503-378-3086

For PA requests, also check one box below:

Routine Processing - 503-378-5814

Justification and additional documentation is required for Urgent or Immediate processing (summarize below). If your PA request does not meet Urgent or Immediate criteria, it will receive Routine processing.

Urgent Processing (72 hours) }
 Immediate Processing (24 hours) } 503-378-3435

Justification: _____

For Provider Enrollment requests: Find required forms and instructions at:

www.oregon.gov/OHA/HSD/OHP/Pages/Provider-Enroll.aspx

For Prior Authorization requests and claim documentation: Find program-specific PA criteria and documentation requirements at www.oregon.gov/OHA/HSD/OHP/Pages/Policies.aspx (click on the link for your program).

Documentation Identification Numbers: Provider ID is required on all requests from providers. To link documents to a specific Recipient ID, PA, claim or other record in our system, enter the appropriate number(s) below. Use one character or number per box; press tab between each entry.

PE Application Tracking Number (ATN):

Provider ID (NPI or Oregon Medicaid ID):

Recipient ID (as listed on the Medical ID):

Prior Authorization Number (PAN):

Internal Claim Number (ICN):

Hearings/Grievances Number (HGN):

Contact Tracking Number (CTN)*:

*For DHS/OHA staff use only: Enter the CTN to link correspondence to a specific Contact Tracking Management System (CTMS) entry. Include CTMS question number and notes number, as applicable. If the CTN is linked to a specific provider or recipient contact, also enter the Provider or Recipient ID.

Confidentiality Notice: The information contained in this packet is confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax - except its direct delivery to the intended recipient - is strictly prohibited. If you have received this packet in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

Provider Enrollment Information

This form is only to enroll providers seeking direct reimbursement from the Oregon Health Authority (OHA). Fields with an asterisk (*) are required if applicable. Failure to complete all required fields will delay processing.

Fax to 503-378-3074 (Salem) under a completed EDMS Coversheet ([MSC 3970](#)) with the following documents:

- Signed and dated [OHA 3974](#) (Disclosure Statement of Ownership and Control Interest)
- Signed and dated [OHA 3975](#) (Provider Enrollment Agreement)
- Provider Enrollment Attachment (if required). To find out which provider types require an attachment, visit the [OHP Provider Enrollment page](#).

This enrollment request is for:

| | |
|--|---|
| <input type="checkbox"/> Individual: Complete Sections I and III. | <input type="checkbox"/> Organization: Complete Sections II and III. |
| Effective date for this enrollment: ____ / ____ / ____ <i>The enrollment effective date cannot be older than 1 year from the date of receipt. If you enter a future date in this field, the effective date will be the date we received your application.</i> | |

I. Individual information

| | | |
|-----------------------|--------------------------------|--------------------------------------|
| *Last name: | *First name: | Middle initial: |
| *Date of birth (DOB): | *Social Security number (SSN): | *National Provider Identifier (NPI): |

II. Organization information

| | |
|---|--------------------------------------|
| *Legal name of agency/facility: | |
| Doing Business As (DBA) name: | |
| *Federal Employer Identification Number (FEIN): | *National Provider Identifier (NPI): |

III. Provider data – Complete for all providers.

A. Enrollment contact information

We may contact this person for questions or additional information required to process this enrollment.

| | |
|-------|--------|
| Name: | Phone: |
|-------|--------|

| | |
|--------|------|
| Email: | Fax: |
|--------|------|

B. *Business type (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Chain | <input type="checkbox"/> Incorporation | <input type="checkbox"/> Not-for-Profit |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Individual Practitioner | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Estate/Trust | <input type="checkbox"/> Limited Liability Corporation (LLC) | <input type="checkbox"/> Public Service Organization |
| <input type="checkbox"/> Government-owned | <input type="checkbox"/> Limited Liability Partnership (LLP) | <input type="checkbox"/> Sole Proprietorship |
| <input type="checkbox"/> Group Practice | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Other: |

C. Address information

Service address – Enter the service or location address where services are rendered. Address must be a physical street address (not a PO Box).

- Personal Care Attendants (PC 20), and Community Nursing Services: Enter your home address as the service address. Do not use your client’s address.

| | | |
|---|-----------------------------|---------------------------|
| *Physical address (include Room/Suite): | | *City, State, ZIP+4 Code: |
| *County: | *Phone (include area code): | *Fax (include area code): |

Mail-To address – Enter only if the address is different from the service address:

| | |
|--|--------------------------|
| Street or PO Box (include Room/Suite): | City, State, ZIP+4 Code: |
|--|--------------------------|

Pay-To address – Enter only if different from the Mail-To address:

| | |
|--|--------------------------|
| Street or PO Box (include Room/Suite): | City, State, ZIP+4 Code: |
|--|--------------------------|

D. License/certification information

| | | |
|--|--|------------------|
| *This information is for (<i>check one</i>): | | *Number: |
| <input type="checkbox"/> License | <input type="checkbox"/> Certification | |
| *Issue date: | *Expiration date: | *State of issue: |

E. Medicare and Medicaid enrollment information

| | | |
|---|------------------------------|-----------------------------|
| Is this an active Medicare provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>If Yes, please list the Medicare Provider ID number below.</i> | | |
| Medicare Provider ID number: | | |
| Is this provider an active Medicaid provider in another state? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>If Yes, please list the Medicaid Provider ID number below.</i> | | |
| Other State Medicaid Provider ID: | State of issue: | |

F. Provider type: Select one provider type that best describes the profession or service.

- | | |
|---|---|
| <input type="checkbox"/> Acupuncturist (02) | <input type="checkbox"/> In-Home Care Agency (93) |
| <input type="checkbox"/> Advance Practice Nurse (42) | <input type="checkbox"/> Independent Labs (29) |
| <input type="checkbox"/> Advanced Comprehensive Health Care (Naturopath) (38) | <input type="checkbox"/> Indian Health Service (28) |
| <input type="checkbox"/> Alcohol/Drug (03) | <input type="checkbox"/> Licensed Clinical Social Worker (69) |
| <input type="checkbox"/> Ambulatory Surgical Provider (05) | <input type="checkbox"/> Licensed Direct Entry Midwife (41) |
| <input type="checkbox"/> Behavior Rehabilitation Specialist (06) | <input type="checkbox"/> Medical Electrolysis (21) |
| <input type="checkbox"/> Billing Provider/Group Clinic (09) | <input type="checkbox"/> Mental Health Personal Care Attendant (30) |
| <input type="checkbox"/> Certified Registered Nurse Anesthetist (37) | <input type="checkbox"/> Mental Health Provider (33) |
| <input type="checkbox"/> Chiropractor (16) | <input type="checkbox"/> Optician (44) |
| <input type="checkbox"/> Community Nursing Agency (88) | <input type="checkbox"/> Optometrist (43) |
| <input type="checkbox"/> Community Nursing Services (86) | <input type="checkbox"/> Oregon State Hospital (35) |
| <input type="checkbox"/> Copy Services (12) | <input type="checkbox"/> Pharmacist (50) |
| <input type="checkbox"/> Dental Hygienist (18) | <input type="checkbox"/> Pharmacy (48) |
| <input type="checkbox"/> Dentist (17) | <input type="checkbox"/> Physician (34) |
| <input type="checkbox"/> Denturist (20) | <input type="checkbox"/> Physician Assistants (46) |
| <input type="checkbox"/> DME/Medical Supply Dealer (36) | <input type="checkbox"/> Podiatrist (19) |
| <input type="checkbox"/> Doula (13) | <input type="checkbox"/> Polygrapher (54) |
| <input type="checkbox"/> Education Agency (62) | <input type="checkbox"/> Portable X-Ray Clinic (52) |
| <input type="checkbox"/> Emergency Response (Lifeline) (92) | <input type="checkbox"/> Psychologist (53) |
| <input type="checkbox"/> End-Stage Renal Disease Clinic (32) | <input type="checkbox"/> Public Health Clinic (47) |
| <input type="checkbox"/> Family Planning Clinic (22) | <input type="checkbox"/> Registered Dietician (58) |
| <input type="checkbox"/> Federally Qualified Health Center (15) | <input type="checkbox"/> RN 1st Assistant (57) |
| <input type="checkbox"/> Freestanding Birthing Center (08) | <input type="checkbox"/> Rural Health Clinic (14) |
| <input type="checkbox"/> Hearing Aid Dealer (23) | <input type="checkbox"/> Targeted Case Management (64) |
| <input type="checkbox"/> Home Health Agency (24) | <input type="checkbox"/> Therapist (45) |
| <input type="checkbox"/> Hospice (27) | <input type="checkbox"/> Transportation Broker (10) |
| <input type="checkbox"/> Hospital (26) | <input type="checkbox"/> Transportation Provider (01) |

G. Specialty and taxonomy information

| | |
|-------------|------------|
| *Specialty: | *Taxonomy: |
| Specialty: | Taxonomy: |