Oregon Health Authority

Provider Enrollment Attachment

to be completed by Rural Health Centers, Federally Qualified Health Centers, Indian Health Service Facilities and Tribal 638 Facility Providers only

(Provider Name and Location for this Enrollment) (Date)

In order to enroll as a Rural Health Center, Federally Qualified Health Center, Indian Health Service (IHS) Facility, or Tribal 638 Facility with Oregon Medicaid and seek direct reimbursement from the Oregon Health Authority (OHA), you must complete this attachment and return it with the following information:

- Completed OHA 3972 (Provider Enrollment Request)
- Signed and dated OHA 3974 (Disclosure Statement of Ownership and Control Interest)
- Signed and dated OHA 3975 (Provider Enrollment Agreement)
- Copy of current license(s), certificates and other documentation requested below

IHS and Tribal 638 facilities that would like to participate in OHA's Tribal Uncompensated Care Program must **also** complete and submit the OHP 3104A (UCCP Provider Enrollment Attachment).

1. Oregon Medicaid provider type *(select one)*.

☐ 14 – Rural Health Clinic
☐ 15 – Federally Qualified Health Center
☐ 28 –Tribal Facility – Select subtype: ☐ IHS Facility **or** ☐ Tribal 638 Facility

2. Enter your current business/license facility number below and **attach a copy** of all license(s) and certificates showing authority to operate in the state in which your facility is located.

License/Registration Number (attach copy)	**Mo/Day/Year of Expiration**

3. If laboratory services are used at the facility, enter the laboratory's CLIA number and **attach a copy** of the current CLIA Certification letter:

4. Select the proof that your facility *(identified by name and address)* is authorized to operate as an RHC, FQHC, IHS or Tribal 638 Facility, and **attach a copy:**

☐ **For RHCs** – Copy of Medicare's letter certifying clinic as RHC.

☐ **For FQHCs** – Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330.

☐ **For FQHC Look-Alikes** - Copy of the letter from CMS designating the facility as a Look-Alike

FQHC *(with **a completed copy** of the grant proposal submitted to HRSA/BPHC).*

- ☐ **For IHS Facilities** – Official documentation that the facility is an IHS facility.
- ☐ **For Tribal 638 Facilities:**
  - ☐ Letter from IHS, applicable Area Office or Central Office, indicating that the facility is a 638 facility; **or**
  - ☐ Written assurance from the Tribe that the facility is owned and operated by the Tribe or a Tribal organization with funding directly obtained under a 638 contract or compact *(with **a copy of the relevant provision** of the current compact or contract).*

5. List any current or previous Oregon Medicaid provider numbers:

6. List any names/business names currently or previously used with the Division or other OHA contracts:

7. Are you employed by a unit of government when providing these services? *Check any government type that applies to this provider.*

☐ County	☐ State
☐ Publicly operated teaching hospital	☐ Transportation district
☐ School district	☐ Tribal
☐ Special purpose district	☐ Other governmental unit (specify):

8. Is the facility Medicare-eligible? *If Yes, **attach a copy** of the Medicare enrollment letter.* ☐ Yes ☐ No

9 Does the facility provide Home Enteral/Parenteral and IV Services or supply such items? ☐ Yes ☐ No

10. Select the financial and cost reporting documentation specific to your provider type and **attach a copy** of these documents. *Failure to submit the required information will delay enrollment.*

☐ **For RHCs:** Copy of Medicare Cost Report; **and** all financial information required to be submitted under OAR 410-147-0320.
☐ **For FQHCs:** All financial information required to be submitted under OAR 410-147-0320 **and** *(select one):* ☐ Justification to adopt the rate of a similar clinic *(identify)*; **or** ☐ A completed OHP 3027 cost statement to have a rate calculated.
☐ **For IHS Facilities:** Rate information; **and** all financial information required to be submitted under OAR 410-146-0020 and 410-146-0021.
☐ **For Tribal 638 Facilities:** All financial information required to be submitted under OAR 410-147-0320 **and** *(select one):* ☐ Adopt the Memorandum of Understanding rate established in the Federal Register; **or** ☐ Attach the OHP 3027 cost statement to have a rate calculated.

11. List the general and professional liability insurance information you have, will maintain, and will provide upon request by OHA or an OHA designee. This is to cover damages caused by error, omission or negligent acts related to the professional services to be provided as an Oregon Medicaid provider.

If you cancel, materially change, reduce limits, or intend not to renew the insurance coverage(s) listed below, you must notify the Division within 30 days of the change:

Carrier Name	**Policy Number**	**Expiration Date**	**Amount insured per occurrence**

12. If you are self-insured for these insurance requirements, enter "Self-Insured" here:

13. Facilities that provide outpatient behavioral health services only:

a. Do you exclusively employ licensed staff? ☐ Yes ☐ No
*If yes, **attach a copy** of a staff list that includes their credentials.*

b. If you decide to hire unlicensed staff, do you acknowledge that you will seek certification from OHA? *If you have questions about the certification process, call 503-945-7818 (Salem).* ☐ Yes ☐ No

c. If you employ unlicensed staff, are you certified by OHA in accordance with OAR 309-012 and 415-012? ☐ Yes ☐ No
*If yes, **attach a copy** of your OHA certification.*

d. Tell us whom you contract with *(check all that apply)*:

☐ OHA
☐ County Mental Health Program
☐ Coordinated Care Organization
☐ Mental Health Organization

14. **Out-of-state providers only:** Enter the name and telephone number of the Medicaid office in your state that can confirm your Medicaid enrollment in that state. **Attach the out-of-state claim** you want to bill Oregon Medicaid.

Medicaid Office Name	**Phone Number**