EDMS COVERSHEET

DHS Oregon Department of Human Services

Oregon Health Authority

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.

- [x] Provider Enrollment (PE) - 503-378-3074
- [ ] Claim Documentation - 503-378-3086
- [ ] Prior Authorization (PA)

For PA requests, also check one box below:

- [ ] Routine Processing - 503-378-5814
- [ ] Urgent Processing *(72 hours)*
- [ ] Immediate Processing *(24 hours)*

} 503-378-3435

- [ ] Hearing Documentation *(no central fax #)*
- [ ] Grievance Documentation *(no central fax #)*
- [ ] Correspondence - 503-378-3086

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.

Justification: REVALIDATION

Personal Care Attendant (PC20) Provider Type 30

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.*

Personal Care Attendant (PC20)
Oregon Medicaid Provider Revalidation Form

Complete this form to revalidate your personal information. Please print or type. Send to:

- Fax with EDMS coversheet to 503-378-3074; if you are unable to fax use one of the other two methods
- Provider Revalidation, 500 Summer St NE E44, Salem OR 97301
- provider.revalidation@dhsoha.state.or.us

All fields are required, if applicable. Incomplete forms will not be validated and may terminate your enrollment effective the day after due date on revalidation notice.

I. Personal Care Attendant information		
Last name:	First name:	Middle initial:
Date of birth (*DOB*):	SSN:	Oregon Medicaid ID:

II. Address information	
Home address (*include apartment/no PO Boxes*):	City, State, ZIP:
Mail-to address (*if different from home address*)	City, State, ZIP:
Phone number (*include area code*)	E-mail (*if available*):

III. Provider Enrollment Agreement

This Enrollment Agreement sets forth the conditions for enrollment as a Provider with the Oregon Health Authority ("Authority" or "OHA") and receipt of an OHA Provider Number in order to submit claims, and receive payment, for health care, services, equipment and/or supplies furnished by the Provider to persons eligible for medical assistance in Oregon ("Recipients"). The Authority makes payments for medical assistance using state funds and federal funds from Medicaid, State Children's Health Insurance Program, or other federally funded programs.

As a condition for participation as a provider with the authority for medical assistance, Provider agrees as follows:

1. **Eligibility and continued participation**
   That the information submitted in the Enrollment Information form, Enrollment Attachment (if applicable), Disclosure Statement (if applicable) and supporting documentation is true and accurate. Provider further understands and agrees that:
   a. Information disclosed by Provider may be subject to verification. The Authority will use this information for purposes related to the administration of the Oregon medical assistance program;

b. Provider will notify OHA of any changes to the information contained in the Enrollment Information form, Enrollment Attachment (if applicable), and Disclosure Statement (if applicable), within 30 days of the date of the change; and

c. Any deliberate omission, misrepresentation or falsification of any information contained in the Enrollment Information form, Enrollment attachment (if applicable) and Disclosure Statement (if applicable) or contained in any communication supplying information to OHA may be punished by law, including but not limited to revocation of the OHA Provider Number and recovery of payments made.

2. **Services**
To provide covered health care, services, equipment or supplies to recipients in accordance with all applicable provisions of statutes, rules and federal regulations governing the reimbursement of services or items under medical assistance programs in Oregon, including OHA Rules, as those laws, rules and instructions may be adopted or amended from time to time. "OHA Rules" means the General Rules (OAR 410 Division 120) and OHA provider rules(s) applicable to the Provider's service category and OHA program that are in effect on the date of service.

   To perform all services for which OHA pays the Provider under this Enrollment Agreement as an independent contractor. Provider is not an "officer," "employee" or "agent" of OHA, as those terms are used in ORS 30.265.

3. **Accurate billing**
To certify by signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the care, service, equipment or supplies claimed were actually provided and medically appropriate, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable OHA Rules and this Agreement.

   The Provider is solely responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's responsibility for the claims submitted on Provider's behalf. OHA may recover any overpayment that OHA made to Provider, by withholding future payments or other processes as authorized by law.

4. **Payment**
To accept the Authority's payment for any care, service, equipment or supplies as payment in full, and not make any additional charge to a Recipient except that specifically allowed by OHA Rules. The Authority determines payment amount and methodology for making a payment using the procedures described in applicable OHA Rules. By accepting payment, Provider certifies compliance with all applicable OHA Rules.

   Provider understands that OHA has sufficient funds currently available and authorized to make payments under this Enrollment Agreement within OHA's biennial budget. Provider further understands that payment for services performed after this biennium is contingent on OHA receiving from the Oregon Legislature appropriations or other expenditure authority sufficient to allow OHA, in its reasonable administrative discretion, to continue to make payments.

5. **Payment**
To comply with federal, state and local laws and regulations applicable to the care, services, equipment or supplies and this Agreement, including but not limited to OAR 410-120-1380. Failure to comply with the terms of this Enrollment Agreement or the OHA Rules may result in

termination, sanctions, or payment recovery, subject to Provider appeal rights, pursuant to OHA Rules.

6. **Recordkeeping and access to records**
To keep such records as are necessary to fully disclose the specific care, services, equipment or supplies provided to Recipients for which reimbursement is claimed, at the time it is provided, in compliance with the applicable OHA Rules in effect on the date of service. Provider is responsible for the completion and accuracy of financial and clinical records and all other documentation regarding the specific care, services, equipment or supplies for which the Provider has requested payment.

   To provide upon reasonable request by the Authority, the Oregon Medicaid Fraud Unit, the Office of Payment Accuracy and Recovery, the Oregon Secretary of State's Office and the federal government, or their duly authorized representatives, immediate access to review and copy any and all records relied on by Provider in support of care, services, equipment or supplies billed to the Oregon medical assistance program. The term "immediate access" means access to records at the time the written request is presented to the Provider.

   a. ***Provider agreements***. OHA must enter into an agreement with each Provider under which the Provider agrees to furnish to OHA or to the Health and Human Services (HHS) secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

   b. ***Information that must be submitted***. A provider must submit, within 35 days of the date of a request by the HHS Secretary or OHA, full and complete information about—

      (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

      (2) Any significant business transactions between the Provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

   c. ***Denial of federal financial participation (FFP).***

      (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the HHS Secretary or OHA under paragraph (b) of this section or under 42 CFR §420.205 (Medicare requirements for disclosure).

      (2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the HHS Secretary or OHA and ending on the day before the date on which the information was supplied.

7. **Confidentiality**
To protect the confidentiality of identifying information that the Provider collects, uses or maintains about a Recipient, the Provider shall only release confidential information with appropriate written authorization of the Recipient or their authorized representative, or for

purposes directly connected with the administration of the Oregon medical assistance program in accordance with applicable federal and state law.

To the extent provider is a covered entity, Provider specifically agrees that it is required to comply with the Health Insurance Portability and Accountability Act (HIPAA), sections 262 and 264 of Public Law 104-191, 42 USC 1320d and federal regulations at 45 CFR Parts 160, 162 and 164, all as amended from time to time, in effect on the date of service.

8. **Security**
   To take reasonable precautions to ensure the security of confidential information, Provider Numbers, all passwords, Personal Identification Numbers (PIN) or other security access codes and the use of all transmission processes such as the web portal or other access portal solely for purposes of the OHA Provider Enrollment Agreement, consistent with OHA Rules and applicable law.

Duration and termination of agreement

This agreement shall remain in effect for no more than five years. Provider or OHA may terminate this Enrollment Agreement by written notice to the other by certified mail, return receipt requested, subject to any specific provider termination requirements in OHA Rules.

Provider signature

PROVIDER: I have read the foregoing agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this Agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action as provided by rule, regulation or statute.

Signature of Provider

Date