



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.

Organization Revalidation Form

Complete this form, the **OHA 3975** and the **OHA 3974** only for the provider listed on your revalidation notice.

Please print or type. Fax completed forms and copy of current license or certification (*if applicable*) with EDMS Coversheet (*attached*) to 503-378-3074.

All fields with (*) are required. Incomplete form(s) will not be processed.

Organization information

*Legal business name		
Doing business as (DBA) if applicable		
*Employer identification number (EIN)	National provider identification (NPI)	*Oregon medicaid ID

Address information

*Service location (<i>include room or suite; no PO Boxes</i>)		*City, State, ZIP +4 code	
*County	*Phone number	Fax number	
Mailing address (<i>if different from service location</i>)		City, State, ZIP +4 code	

Provider Contact Information

*Contact name	*Contact phone number
*Contact email	