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.

- ☒ 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: NEW REVALIDATION - ORGANIZATIONS

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.*

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Sole Proprietor Revalidation Form

Complete this form and the **OHA 3975** 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.

Provider information

*Last name	*First name	Middle initial

*Date of birth	*SSN	National provider identification (NPI)	*Oregon Medicaid ID

If using an employer identification number (EIN) for tax purposes, please complete this section.
Doing business as (DBA)
Employer identification number (EIN)

Address information

*Service location *(include room or Suite; no PO boxes)*	*City, State, ZIP +4 code

*County	*Phone	Fax

Mailing address *(if different from service location)*	City, State, ZIP +4 code

Provider contact information *(if different from provider)*

Contact name	Contact phone number

Contact email