Oregon Medicaid

(Oregon Health Plan)

What is this request for? – *choose one*

See instructions on page 2 for required forms.

- ☐ New or re-enrollment
- ☐ Provider update – actively enrolled
- ☐ Revalidation - *check box **only** if request is for a provider who received notice to revalidate or has been instructed to complete by Provider Enrollment*

Definitions and enrollment information – *choose one*

- ☐ Payable Individual

  Payable Individual – Individual provider who is enrolling to bill Oregon Medicaid directly (not through an organization) for services using their individual National Provider Identifier (NPI). This includes Sole Proprietors who intend to use their Social Security Number (SSN) or their Federal Employer Identification Number (FEIN) and associated name for payment / tax purposes.

- ☐ Organization

  Organization – Groups, clinics, LLC, non-profit, etc., who is enrolling to bill Oregon Medicaid for services rendered by individual providers using the organizations National Provider Identifier (NPI).

Business type – check all that apply *(organizations only)*

Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Is the Provider owned or operated by a State, county, city or other local governmental agency or instrumentality? ☐ Yes ☐ No

- ☐ Corporation
- ☐ Government-owned
- ☐ Limited Liability Corporation (LLC)
- ☐ Limited Liability Partnership (LLP)
- ☐ Limited Partnership
- ☐ Not-for-profit
- ☐ Partnership
- ☐ Professional Corporation
- ☐ Other: *(enter below)*

General information

All Providers as defined in OAR 410-120-1260(3)(a) are required to enroll with Oregon Medicaid. OHA may deactivate providers who do not have any claim activity in an 18-month period. OHA recommends that you enroll if you have rendered services to an Oregon Medicaid Member in the last 12-months or plan to see a member within the next 30 days.

Provider Enrollment reserves the right to make necessary changes to the information submitted such as provider type, specialty, and taxonomy. This action is necessary to correctly enroll the provider.

Disclosure information

Disclosure of Social Security Number is required pursuant to 41 USC 405(c)(2)(C)(i) to establish identification, 42 CFR 455.104 and 455.436 for exclusion verification and 26 CFR 301.6109-1 for the purpose of reporting tax information. OHA may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the name, Social Security Number (SSN) or Federal Employer Identification Number (FEIN) provided on this application.

Instructions for submitting forms

The OHA 3972 is to enroll, re-enroll, update, or revalidate providers seeking direct reimbursement from the Oregon Health Authority (OHA). Failure to complete required sections will delay processing.

- Fax **all** pages of form(s), starting with the EDMS Coversheet to 503-378-3074.
  Or
- Submit completed form(s) online. See ***Provider Enrollment Guide*** on Provider Enrollment webpage.
- OHA 3972 (Provider Enrollment Information)
- OHA 3974 (Provider Disclosure Statement – organizations only) – ***not required for general updates disclosed on the OHA 3972.***
- OHA 3975 (Provider Enrollment Agreement) – ***not required for updates.***
- Provider Enrollment Attachment – To find out which attachment your provider requires, visit the OHP Provider Enrollment page. ***Not required for updates or revalidations***
- Other – include any additional documentation listed in the required documents section of the OHP Provider Enrollment web page or as stated within this form.

Outdated forms are not accepted. Visit the OHP Provider Enrollment Website:
https://www.oregon.gov/OHA/HSD/OHP/Pages/Provider-Enroll.aspx

You may call or email Provider Enrollment 48 hours after faxing your application to verify receipt. 800-336-6016, option 6. Enrollment forms are not accepted via email.
Provider.Enrollment@odhsoha.oregon.gov

If this request is for a provider who is providing telehealth services fee-for-service or open card OHP members, the provider is required by OAR 410-120-1990 to hold an unencumbered Oregon license. If the provider is out-of-state, the provider is also required by OAR 410-120-1260 to be licensed in the state where the provider is located. The service location on this application should reflect where the provider is physically located, and the license should reflect the Oregon license.

Is this request for a telehealth provider? ☐ Yes ☐ No

Payable individual provider information (required – only complete if application selection on page 1 is for payable individual)

Last name:	First name:	Middle Initial:
Social Security Number (SSN):	Date of birth (DOB):	
Doing Business As (DBA) name *(if applicable)*:		
Federal Employer Identification Number (FEIN) *if applicable*:		
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:	

Organization provider information *(required – only complete if application selection on page 1 is for organization)*

Legal name:	
Doing Business As (DBA) name *(if applicable)*:	
Federal Employer Identification Number (FEIN):	
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:

Type, Specialty, and Taxonomy information (required)

See type and specialty list on Provider Enrollment webpage.

Provider Type Code:
Specialty Description:
Primary Taxonomy Number:
Secondary Taxonomy Number (optional):

Physical therapists only: Does the provider provide services exclusively in a patient's home, in their personal home, in an institutional setting or a school setting? ☐ Yes ☐ No

Address information *(required)*

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

Note – *This is the address where a site visit may be conducted.*

- SPD Nursing Services *only*: Enter your home address as the service address. Do not use your client's address.

Physical address (include Room/Suite):	City:	State:	Zip Code:	+4:
County:	Phone:	Ext.:	Fax:	

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

Street or PO Box (include Room/Suite):	City:	State:	Zip Code:	+4:

Pay-To address – *Enter only if this address is different from the Mail-to address:*

Street or PO Box (include Room/Suite):	City:	State:	Zip Code:	+4:

License/certification information *(required, if applicable)*

This information is for *(check one)*: ☐ License ☐ Certification	Number:
Issue date:	Issuing board:
Expiration date:	Issuing state:

Enrollment contact – *missing contact may delay processing*

Enrollment Contact name:	Contact email:
Contact phone number:	Contact fax number:

EFT financial contact – only

Complete this section with the contact information for the individual who can be contacted for financial related questions / validation.

Contact name:	Contact email:
Contact phone number:	Contact fax number:

Medical records contact – only

Complete this section with the contact information for the individual who can be contacted for medical records as needed for audit purposes.

Contact name:	Contact email:
Contact phone number:	Contact fax number:

Billing contact – only

Complete this section with the contact information for the individual or organization who can be contacted regarding billing and claims.

Contact name:	Contact email:
Contact phone number:	Contact fax number:

Clinical Laboratory Improvement Amendments (CLIA) – *(if applicable)*

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

Adult Foster Homes - *only (required)*

Under section 1615(c) of the Social Security Act (Medicaid Waiver payments), you may be qualified to have certain Medicaid payments be excludable from income. Please carefully review information provided on www.irs.gov for more information about this Medicaid Waiver payment.

The link below has been provided as a starting point for your review.

https://www.irs.gov/individuals/certain-medicaid-waiver-payments-may-be-excludable-from-income

Based on information provided at www.irs.gov do you meet the qualifications for Medicaid Waiver payments? ☐ Yes ☐ No

Please be aware that if you mark "yes" and you do not meet the qualifications for the Medicaid Waiver payment, you may be subject to a Provider Sanction under OAR 410-120-1400 and OAR 410-120-1460.

Outpatient Behavior Health (MH / SUD) – *only (required)*

Is your facility/organization comprised exclusively of Oregon licensed practitioners? If yes, attach a list of practitioners that includes their name, NPI and license number.

☐ Yes ☐ No (see below for requirements)

If you employ or contract with unlicensed staff such as QMHA, QMHP, CADC's or Student (Master's level) Interns you must be certified in accordance with OAR 309-008 and 415-012. ***attach copy of OHA Certificate of Approval (COA) issued by HSD (formerly AMH)***

Note: *pursuant to OAR 410-172-0660, board-registered interns do not need a COA for enrollment purposes.*

If you have questions about the certification process, contact the Licensing and Certification Unit. Find current contact information at

http://www.oregon.gov/OHA/HSD/AMH-LC/Pages/Contacts.aspx.

Out-of-state providers: In accordance with OAR 410-172-0660, If the facility/organization is providing behavioral health services, only staff licensed by an Oregon Board may serve an Oregon Medicaid Member. In addition, the facility/organization may enroll only if it's comprised exclusively of health care practitioners or behavioral health care practitioners as outlined in OAR 309-008-0250(4)(b).

ABA Organizations – *only (required)*

ABA organizations are required to have a licensed therapist that all providers are practicing under in accordance with OAR 410-172-0760. ***Attach copy of BCBA license of the designated licensed therapist for this location.***

Should the designated licensed therapist change, it is your responsibility to notify OHA of this change and provide a copy of the license to support this change.

Polygrapher – *only (required)*

A sex offender polygrapher examiner specialist must have a general working knowledge of sex offenders, victims, treatment techniques, and ethical obligation as evidenced by one of the following.

☐ Participation and successful completion of an approved training offered by Oregon Adolescent Sex Offender Treatment Network ***(attach certificate of completion);*** or

☐ Participation in an approved training pertaining to the treatment of sex offenders ***(attach documentation of attendance and successful completion)***; or

☐ A letter from a licensed therapist or counselor who provides treatment to sex offenders, attesting to your knowledge as described above ***(attach copy)***.

Enrollment effective date – *(for new providers and inactive providers only)*

Effective date requested for this enrollment (mm/dd/yyyy):

The effective date may be backdated up to one year from date received. If no effective date is provided, date of receipt will be used. Updates are effective the date received, and revalidation effective date is dependent on all information requested being received complete and accurate.

Provider or authorized representative signature

I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Oregon Medicaid Program and/or prosecution for Medicaid fraud.

Print name of Provider or representative	Title
Signature of Provider or representative	Date

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Equity and Inclusion Division at languageaccess.info@odhsoha.oregon.gov or 1-844-882-7889. We accept all relay calls.