

## Oregon Medicaid Enrollment Form

*[All fields required unless otherwise noted]*

### Plan Information

Plan Name: Health Share of Oregon
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### Claim Information

Claim Number (if applicable):	DOS:
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Not applicable (Current authorization to see member, or a new hire, but no claims billed yet.)

### Addresses Information

Facility/Office Street Address:	
Facility/Office City, State, Zip+4:	
Office Phone:	Office Fax:

### Identification Numbers

*For Rendering/Attending Physician(s)*

Name:	NPI:	
State Medical License (required):	Effective Date:	Expiration Date:
Taxonomy Code:		
Social Security Number*:	Date of Birth*:	

**\* Required by CMS rule CMS-6028-FC**

Not applicable (Submitting enrollment request for organizational Provider only.)

*For Submitting/Organizational Provider*

Name:	NPI:
Taxonomy Code:	

Not applicable (Submitting enrollment request for Rendering/Attending Physician only.)

Hospitals, Skilled Nursing Facilities, Home Health, and ESRD must fill in your license information below and attach a copy of your current license.

Laboratories please fill in your CLIA number information below, and attach a copy of your current CLIA.

Hospital License Number:	Effective Date:	Expiration Date:
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The following information is required in order to acquire a Medicaid number for the organizational NPI.

The following information must be supplied for all owners and officers with a **controlling interest of 5% or more** in the company. If no one person is an owner or has a controlling interest if 5% of more, the following information will need to be supplied for the CEO, COO, or controlling officer in the company. \*

Please include additional sheets if necessary.

Name*	Title*	Date of Birth*	SSN*

\* Required by CMS rule CMS-6028-FC

Not applicable (Submitting enrollment request for Rendering/Attending Physician only.)

An Oregon Medicaid number must be acquired for all submitting and rendering/attending NPI numbers on the claim in order to receive payment.

**\*\*\*\*\* PLEASE INCLUDE YOUR MOST RECENT SIGNED AND DATED W9 AND (if applicable) A COPY OF YOUR FACILITY LICENSE \*\*\*\*\***

Please return the completed form along with your most recent signed and dated W9, and any other required documents to [map.enrollment@phtech.zendesk.com](mailto:map.enrollment@phtech.zendesk.com), or fax to 503-315-4138, Attn: MAP Enrollment.

For questions regarding the status of your pending enrollment, please call the Provider Enrollment Department at PH Tech at 503-584-2169, option 2.