



Pathways Provider Request Addition of Contracted Services to Existing Agreement

Currently contracted Pathways Providers, please complete this form to request the addition of new Mental Health or SUD services to your contract.

Provider Name:

Date Form Completed:

Name of Contact:

Contact Email:

Provider Tax ID:

List ALL Practitioners who will be providing these services:

List ALL office locations (name and address) at which these services will be provided:

How long have you been providing these services to Oregon Medicaid members?

Do you have a Certificate of Approval issued by OHA, or applicable licensure, to provide these services?

YES NO In Process

If 'Yes', please include a copy of the applicable COA or license along with this request.

If 'In Process', when did you submit your application?

Be aware that our credentialing team will confirm appropriate licensure, certifications, etc before we can review your request to add services to your contract.

Please indicate on the next two pages which Mental Health and / or Substance Use Disorder Services you are requesting to have added to your contract.

Mental Health Services provider is requesting to have added to contract

Service Type <i>(check all that apply)</i>	Age(s) Served* <i>(check all that apply)</i>			
<input type="checkbox"/> ABA	<input type="checkbox"/> Child	<input type="checkbox"/> Youth		
<input type="checkbox"/> ACT			<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> CBIT	<input type="checkbox"/> Child	<input type="checkbox"/> Youth		
<input type="checkbox"/> Crisis Stabilization	<input type="checkbox"/> Child	<input type="checkbox"/> Youth		
<input type="checkbox"/> DBT - Fidelity	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Eating Disorder-Partial Hospitalization	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Eating Disorder-Residential	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> IDD Medication Management	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Inpatient Psychiatric Hospitalization	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Mental Health IOP/Partial Hospitalization			<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Mental Health Outpatient	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Mental Health Outpatient: SMI			<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Psychiatric Day Treatment Services	<input type="checkbox"/> Child	<input type="checkbox"/> Youth		
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Child	<input type="checkbox"/> Youth	<input type="checkbox"/> Adult	<input type="checkbox"/> Older Adults
<input type="checkbox"/> Respite Services	<input type="checkbox"/> Child	<input type="checkbox"/> Youth		
<input type="checkbox"/> Sub-Acute Services	<input type="checkbox"/> Child	<input type="checkbox"/> Youth		

***Child:** Ages 0-5 | **Youth:** Ages 6-17 | **Adult:** Ages 18-64 | **Older Adult:** Ages 65 and up

Not requesting addition of Mental Health Services

SUD services on the next page

Substance Use Disorder Services provider is requesting to have added to contract

Service Type <i>(check all that apply)</i>		Age(s) Served* <i>(check all that apply)</i>							
<input type="checkbox"/>	SUD Dual Diagnosis Residential (Level 3.5)	<input type="checkbox"/>	Child	<input type="checkbox"/>	Youth	<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD High Intensity Medically-Monitored Residential Treatment Services (Level 3.7)					<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD Medication Assisted Treatment (Opioid Treatment Program)					<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD Medication Assisted Treatment (Office Based Opioid Treatment)					<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD Outpatient (Levels 1 and 2.1)	<input type="checkbox"/>	Child	<input type="checkbox"/>	Youth	<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD Partial Hospitalization/Day Treatment (Level 2.5)	<input type="checkbox"/>	Child	<input type="checkbox"/>	Youth	<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD Residential Treatment	<input type="checkbox"/>	Child	<input type="checkbox"/>	Youth	<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults
<input type="checkbox"/>	SUD Withdrawal Management / Detox (Level 3.7-WM)	<input type="checkbox"/>	Child	<input type="checkbox"/>	Youth	<input type="checkbox"/>	Adult	<input type="checkbox"/>	Older Adults

***Child:** Ages 0-5 | **Youth:** Ages 6-17 | **Adult:** Ages 18-64 | **Older Adult:** Ages 65 and up

Not requesting addition of Substance Use Disorder services

Please be aware that completing this form **does not guarantee** the addition of the services to your Provider Agreement. If you are providing Health Share members with services for which you are not contracted, services may not be reimbursed and, per OAR 410-120-1280, the member may not be billed.

If you have questions about this form or your existing contract with Health Share, please contact our Contracting and Provider Network Development Department at 971-334-8056 or providers@healthshareoregon.org.

Once complete, please this form, and any supporting documentation to providers@healthshareoregon.org for review.