**Oregon Medicaid Enrollment Form**

*[All fields required unless otherwise noted]*

**Plan Information**

Plan Name: Health Share of Oregon

**Claim Information**

|  |  |
| --- | --- |
| Claim Number (if applicable):        | DOS:       |

[ ]  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:      |

*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, 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 503-315-4130.