health share PATHWAYS PH TECH

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.