**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** *(check all that apply)* | | **Age(s) Served\*** *(check all that apply)* | | | | | | | |
|  | ABA |  | Child |  | Youth |  |  |  |  |
|  | ACT |  |  |  |  |  | Adult |  | Older Adults |
|  | CBIT |  | Child |  | Youth |  |  |  |  |
|  | Crisis Stabilization |  | Child |  | Youth |  |  |  |  |
|  | DBT - Fidelity |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Eating Disorder-Partial Hospitalization |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Eating Disorder-Residential |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | IDD Medication Management |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Inpatient Psychiatric Hospitalization |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Mental Health IOP/Partial Hospitalization |  |  |  |  |  | Adult |  | Older Adults |
|  | Mental Health Outpatient |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Mental Health Outpatient: SMI |  |  |  |  |  | Adult |  | Older Adults |
|  | Medication Management |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Psychiatric Day Treatment Services |  | Child |  | Youth |  |  |  |  |
|  | Psychological Testing |  | Child |  | Youth |  | Adult |  | Older Adults |
|  | Respite Services |  | Child |  | Youth |  |  |  |  |
|  | Sub-Acute Services |  | Child |  | 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** *(check all that apply)* | **Age(s) Served\*** *(check all that apply)* |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | SUD Dual Diagnosis Residential  (Level 3.5) |  | Child |  | Youth |  | Adult |  | Older Adults | |  | SUD High Intensity Medically-Monitored Residential Treatment Services (Level 3.7) |  |  |  |  |  | Adult |  | Older Adults | |  | SUD Medication Assisted Treatment  (Opioid Treatment Program) |  |  |  |  |  | Adult |  | Older Adults | |  | SUD Medication Assisted Treatment  (Office Based Opioid Treatment) |  |  |  |  |  | Adult |  | Older Adults | |  | SUD Outpatient (Levels 1 and 2.1) |  | Child |  | Youth |  | Adult |  | Older Adults | |  | SUD Partial Hospitalization/Day Treatment (Level 2.5) |  | Child |  | Youth |  | Adult |  | Older Adults | |  | SUD Residential Treatment |  | Child |  | Youth |  | Adult |  | Older Adults | |  | SUD Withdrawal Management / Detox  (Level 3.7-WM) |  | Child |  | Youth |  | Adult |  | 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](mailto:providers@healthshareoregon.org).

Once complete, please this form, and any supporting documentation to

[providers@healthshareoregon.org](mailto:providers@healthshareoregon.org) for review.