



## Health Systems Division Provider Agency Information Request Form

### Provider Information

Provider Agency Name \_\_\_\_\_

Corporate Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code (5 digits) \_\_\_\_\_

County \_\_\_\_\_ MMIS # \_\_\_\_\_

Phone (ext.) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code (5 digits) \_\_\_\_\_

Phone (ext.) \_\_\_\_\_ Fax \_\_\_\_\_

TTD \_\_\_\_\_ NPI # \_\_\_\_\_

### Contacts

Contact Name \_\_\_\_\_

Title \_\_\_\_\_

Phone (ext.) \_\_\_\_\_ Cell \_\_\_\_\_

E-mail Address \_\_\_\_\_

Contact Name \_\_\_\_\_

Title \_\_\_\_\_

Phone (ext.) \_\_\_\_\_ Cell \_\_\_\_\_

E-mail Address \_\_\_\_\_

Contact Name \_\_\_\_\_

Title \_\_\_\_\_

Phone (ext.) \_\_\_\_\_ Cell \_\_\_\_\_

E-mail Address \_\_\_\_\_

E-mail completed electronic copies of this form to [BHA.DocumentSupport@state.or.us](mailto:BHA.DocumentSupport@state.or.us).

Mail printed copies to: Health Systems Division

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