OREGON HEALTH AUTHORITY

Provider Enrollment Request for Coordinated Care Organization (CCO) Providers

Contracted CCOs must use this form to enroll their providers.

FFS organizations must enroll their non-payable providers using the OHP 3113.

Fields marked with an asterisk (*) are required if applicable.

Request information

1. Name of the Plan requesting enrollment*: _____
2. Contact name for this request*: _____
3. Contact phone number*: _____
4. Effective date requested for this enrollment*: _____

   If this date is more than 6 months earlier than the date the Division receives the request, your liaison will contact you for additional information.

5. If this request is for a provider who is providing telehealth services, the provider is required by OAR 410-120-1990 to hold an unencumbered Oregon license. If the provider is out-of-sate, the provider is also required by OAR 410-120-1260 to be licensed in the state where the provider is located. The service location on the application should reflect where the provider is physically located, and the license should reflect the Oregon License. A copy of both licenses should be attached to the enrollment request.

   Is this request for a telehealth provider?

   ☐ Yes ☐ No

6. Is this enrollment for an (select one)*: ☐ Individual provider ☐ Organization

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Individual provider information

1. Provider's name*: _____
2. Date of birth*: _____
3. Social Security number*: _____

Organization information

1. Business name*: _____
2. Federal Employer Identification Number (FEIN)*: _____
3. Organization type*: Check the entity type that best describes the structure of the enrolling provider entity, agency, facility or organization. Check only one box.

   ☐ For-profit corporation ☐ Non-profit corporation ☐ Partnership

   ☐ Government-owned ☐ Sole proprietorship ☐ Tribal-owned

   ☐ LLC ☐ PC

4. Is the Provider owned or operated by a State, county, city or other local governmental agency or instrumentality?*

   ☐ Yes ☐ No

Enrollment information

1. License/certification information*: License number: _____

   License board: _____ State of Issue: _____

   Effective date: _____ Expiration date: _____

2. NPI (as registered with NPPES)*: _____

3. Taxonomy codes: If entering more than one code, list the primary first.

   Primary*: _____ Description: _____

   Secondary: _____ Description: _____

   Other: _____ Description: _____

4. Provider type*. Using the list on page 5, enter the provider type for this request:

   _____

* Additional information required for provider type 45 with specialty 420 physical therapy for site visits, must be completed on the Organization at the service location of the provider.

☐ Therapist (45)

- ☐ Occupational
- ☐ Audio/speech
- ☐ Audiologist
- ☐ Physical (see question below)
- ☐ Speech/language pathologist
- ☐ Speech/hearing therapist

Physical therapists only: Do you provide services exclusively in a patient's home, provider's personal home, institutional setting, or a school?

☐ Yes ☐ No

Group affiliation (please note that the group affiliation(s) have no impact on claims):

Primary organization name: _____

Organization NPI: _____

Organization Medicaid ID: _____

Organization tax ID: _____

5. Provider specialty (if applicable): _____

6. Service location* - Address must be a physical street address (not a PO Box):
   Physical address (include Room/Suite):

   _____

   City: _____ State: _____

   ZIP code: _____ County: _____

   Business phone (include area code): _____

7. Mailing address (if different from service location):
   Street or PO Box (include Room/Suite):

   _____

   City: _____ State: _____ Zip code: _____

8. Site Visit Contact Information*:

   Contact name: _____

   Contact email: _____ Contact phone: _____

9. For active Medicare providers, please provide the following information:

   Medicare Provider ID*: _____

   Effective date*: _____ Expiration date: _____

10. For active Medicaid providers, please provide the following information:

    Medicaid Provider ID*: _____ State of issue*: _____

    Effective date*: _____ Expiration date: _____

DHS | OHA Provider Types

Refer to this list to enter your provider type information on page 3 of this form.

1	Transportation Provider
2	Acupuncturist
3	Alcohol/Drug
5	Ambulatory Surgical Provider
6	Behavioral Rehab Specialist
7	Billing Service
8	Freestanding Birthing Center
9	Billing Provider /Group Clinic
10	Transportation Broker
12	Copy Services
13	Traditional Health Worker
14	Rural Health Clinic
15	FQHC
16	Chiropractor
17	Dentist
18	Dental Hygienist
19	Podiatrist
20	Denturist
21	Medical Electrolysis
22	Family Planning Clinic
23	Hearing Aid Dealer
24	Home Health Agency
26	Hospital
27	Hospice
28	Indian Health Clinics
29	Independent Labs
30	Mental Health Personal Care Attendant
32	End-Stage Renal Disease Clinic
33	Mental Health Provider
34	Physician
35	Oregon State Hospital
36	DME/Medical Supply Dealer
37	Certified Registered Nurse Anesthetist
38	Advanced Comprehensive Health Care (Naturopath)
41	Midwife
42	Advance Practice Nurse
43	Optometrist
44	Optician
45	Therapist
46	Physician Assistants
47	Clinic
48	Pharmacy
49	Prenatal Clinic
50	Pharmacist
52	X-Ray Clinic
53	Psychologist Provider
54	Polygrapher
57	RN 1st Assistant
58	Registered Dietician
60	Smoking Cessation
61	Lactation Consultant
62	Education Agency
63	National Diabetes Prevention Program Supplier. Specialty codes: • 497 for in-person program • 498 for online program.
64	Targeted Case Management
65	Translator
66	Emergency Medical Services (EMS)
68	Health Related Social Needs (HRSN)
69	Social Worker
70	Foster Care
71	Child Foster Care
72	SPD Transportation
73	Home Care Worker
74	Client Support Services
75	Case Management
76	County Services
77	Adaptive Modification
78	Habilitation
80	Intermediate Care Facility /Mental Retardation
81	Nursing Facility
82	APD Nutritionist
83	Behavioral Consultant
84	Personal Assistant
86	APD Nursing Services
88	Nursing Agency
89	DD Living Facilities
91	APD Living Settings
92	Emergency Response (Lifeline)

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Provider Enrollment at provider.enrollment@odhsoha.oregon.gov or 1-800-336-6016 (voice). We accept all relay calls.

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