Vendor Configuration Request Form

www.advancedhealth.com/providers

Notice: *All providers must have an active Oregon Medicaid provider ID number in accordance with OAR 410-120-1260. This form is only for use by providers and vendors with a valid Oregon Medicaid provider ID. Please contact emilie.wilson@advancedhealth.com to request the appropriate enrollment forms.*

Contact Information:
Name of individual completing this form:
Organization:
Phone Number:
Email Address:
Fax Number:

Billing Provider (Vendor) Information:
Organization name:
National Provider Identifier (NPI):
Oregon Medicaid Provider ID Number (REQUIRED):
Taxonomy code:
Earliest service date:

Payment Information:
Federal Tax ID (or SSN):
"Pay To" Name (If different than Organization Name):
Receive Electronic Funds Transfers (EFT)? NO: ☐ YES: ☐ *if yes, requires a bank letter confirming account relationship
EFT bank name:
EFT routing number:
EFT account number:
Choose One: ☐ Savings Account ☐ Checking Account
If you would like to Receive EOB's via secure email, please provide a valid email address where you would like them delivered. EOB Email Address:

Billing Address Information:		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Billing Contact Name:		
Billing Contact Phone Number:	Billing Contact Fax Number:	
Billing Contact Email Address:		

****Please return completed form(s) via fax to 541-266-0141 or email to emilie.wilson@advancedhealth.com. If EFT information is included please use secure email.**

Provider Configuration Request Form

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Instructions: *Please complete this for each associated provider you wish to add or update.*

RENDERING/ATTENDING/REFERRING PROVIDER INFORMATION

Miscellaneous:
Associated Billing Provider Organization:
Billing Provider NPI:
Association Date:

Provider Information:			
Last Name:	First Name:	Middle:	Suffix:
National Provider Identifier (NPI):			
Oregon Medicaid Provider ID Number (REQUIRED):			
Taxonomy:			
Earliest Service Date:			

Credentials:	
Primary Licensing organization:	License Number:
Secondary Licensing Organization:	License Number:

Physical Address (No P.O. Boxes):		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Office Contact Name:		
Office Contact Phone Number:	Office Contact Fax Number:	
Office Contact Email Address:		

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