AdvancedHealth
Bridging the Future of Healthcare
289 LaClair St. | Coos Bay, OR 97420
Main: 541-269-7400
Toll Free: 800-264-0014
TTY: 800-264-0014

NOTICE
~Additional Information Required~

Date:

From: Advanced Health
Provider Enrollment

Phone: 541-269-7400
Fax: 541-266-0141

Dear Medical Services Provider:

We have received a claim on your behalf and have found that the facility and/or attending provider are currently not recognized in the State of Oregon's Medicaid System as a performing provider and we are unable to submit the claim to the State's Medicaid system.

In order for Advanced health to be able to process the claim, you will need to complete the application on the included with this letter and fax it and a copy of your claim to Advanced Health at 541-266-0141. In turn, Advanced Health will submit the application to the State Medicaid office to request that a performing provider ID number (DMAP number) be issued. Please note that it can take up to 45-60 days for the State to issue an ID number once your application is received. *Your cooperation in returning your application and claim in a timely manner is greatly appreciated.*

Notice: *The State of Oregon, Oregon Health Authority (OHA,) requires all health care providers and suppliers to submit both Social Security Numbers and Date of Birth information when initially enrolling or revalidating their participation with an Oregon Coordinated Care Plan. OHA is taking this action as required under Section 6401 of the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010. The CMS final rule addressing Section 6401 of the PPACA is CMS-6028-FC.*

Please complete the application and fax it with a copy of your claim and a W-9 to:

Fax to:
Advanced Health
Attn: Provider Enrollment
Fax: 541-266-0141

Mail it to:
Advanced Health
Provider Enrollment
289 Laclair Street
Coos Bay, OR 97420

Thank you for your assistance to ensure Oregon Medicaid funds are used as efficiently as possible for our covered members. Feel free to contact us with any questions.

AdvancedHealth
Bridging the Future of Healthcare

Oregon Medicaid - Provider Application

289 Laclair Street, Coos Bay, OR 97420
Ph: 541-269-7400 Fax: 541-266-0141

1 Last Name First Name MI Gender	2 Business Name (if different)
3 Physical Service Address	4 Billing Address (if different)
City State Zip	City State Zip
5 Billing Contact Area Code and Phone #	6 Billing Contact Email Address
7 Organization (W-9 Required) ☐ Corporation ☐ Sole Proprietor ☐ Tribal ☐ Partnership ☐ Government Owned ☐ Not for Profit ***(IRS Affirmation Letter Required)***	8 State Licensing Board / 9 State License Number 10 License Effective Date / 11 License Expiration Date
12 Provider Type / 13 Specialty Type	14 Requested DMAP Effective Date
15 NPI #	16 Taxonomy Code(s)

17 Required Identification Number Type:

(Medical Provider) ☐ Provider's Full Name: _____
First MI Last

(HOSPITAL Only) ☐ Hospital Administrator' Full Name: _____
First MI Last

(Ancillary Provider) ☐ Owner/Administrators Name: _____
First MI Last

☐ Social Security Number of individual above: _____

☐ Date of Birth of individual above: _____

22 Business Tax Identification Number (FEIN)	23 Business NPI

24 **Are there any persons with 5% or more ownership**: ☐ Yes ☐ No
(If Yes, please include the name of the individual(s) and their date of birth. Attach another page if necessary.)

Name: _____ Date of Birth: ____/____/_____

Name: _____ Date of Birth: ____/____/_____

Name: _____ Date of Birth: ____/____/_____

Fax completed application, claim & W-9 back to: Advanced Health, Attn: Provider Enrollment. at 541-266-0141.

*****For Office Use Only*****		
ATN	ATN Entry Date	Notes
Enrolled From/To	DMAP #	
Provider #	Vendor #	

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

Purpose

Federal law requires fiscal agents, managed care entities (MCEs), and other Oregon Medicaid providers, including applicants and certain bidders seeking to provide Oregon Medicaid services, to disclose all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3.

Instructions

For these disclosures, the Oregon Health Authority (OHA) requires fiscal agents, MCEs, and other providers to complete this form entirely.

Submit tax identification numbers (TINs) for all individuals or entities reported using this form. Submit a Social Security number (SSN) for all individuals, and Employer Identification number (EIN) for all entities.

OHA requires SSNs in order to conduct the provider screenings required by 42 CFR § 455 Subpart E. See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice *(page 1 of the Information and Instructions at the end of this form)* to learn more about this requirement.

For questions about filling out this form, see the Information and Instructions (after page 5 of this form). Form will not be accepted if missing information such as TIN or DOB. Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, termination of its agreement or contract.

Please check each box that explains the reason for disclosure:

☐ New enrollment ☐ Reactivated enrollment ☐ Revalidation

☐ Change in ownership ☐ Change in managing employees

Contact name:
Contact phone:
Contact email:

Provider NPI #:

Section I. Disclosing entity information

Legal name of provider *(individual, agency, facility or group)*:	
Doing Business As (DBA):	
TIN *(SSN for individual, EIN for entity)*:	**Service address:**
National Provider Identifier (NPI):	

Section II. Disclosure information

In this section, please report the following information:

Owner (5% or more):
List the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. For individuals, include DOB and SSN; for corporations, include TIN.

Subcontractor:
List all subcontractors who are related to the disclosing entity owners as a spouse, parent, child or sibling, where the disclosing entity has a 5% or more interest in the subcontractor.

Managing employee:
List the name, address, DOB and SSN of any managing employee of the disclosing entity.

Other interest:
List the name of any other disclosing entity or fiscal agent or managed care entity in which the owner of the disclosing entity has an ownership or control interest; or of any other individual or entity with other interest. Other interest in the provider can be:

- The owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity;
- An officer or director of the entity, if the entity is organized as a corporation; or
- Partner in the entity, if the entity is organized as a partnership.

Sanctions, exclusions or convictions:
Indicate whether the individual or entity reported on this form has experienced any of the following:

- **Sanction or exclusion** from participation in Medicare or any state health care programs;
- **Conviction** for a criminal offense or assessed civil penalties related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs, or as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act; **or**
- Transfer of their ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following any of these events.

Provider NPI #:

Disclosure # 1	
Person type. *Who is this disclosure for? Check one:* ☐ Individual ☐ Corporation	
Disclosure type. *Check all that apply:* ☐ Owner (5% or more) ☐ Subcontractor ☐ Managing employee ☐ Other interest	
Name	**Address** *(If corporate, list primary business address and PO Box if applicable)*
TIN *(SSN for individual, EIN for corporation)*	
Date of birth	

Sanctions, exclusions or convictions (42 CFR §455.100)

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? *Must select Yes or No. If Yes, check all that apply:* ☐ Yes ☐ No

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

Relationships

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

Name	**Relationship**

Other ownership or control interest

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

Provider NPI #:

Additional Disclosures (make copies as needed)	
Person type. *Who is this disclosure for? Check one:*	
☐ Individual	☐ Corporation
Disclosure type. *Check all that apply:*	
☐ Owner (5% or more)	☐ Subcontractor
☐ Managing employee	☐ Other interest
Name	**Address** *(If corporate, list primary business address and PO Box if applicable)*
TIN *(SSN for individual, EIN for corporation)*	
Date of birth	

Sanctions, exclusions or convictions (42 CFR §455.100)

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? **Must select Yes or No. If Yes, check all that apply:* ☐ Yes ☐ No

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

Relationships

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

Name	**Relationship**

Other ownership or control interest

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

Provider NPI #:

Section III. Business transactions: Only complete at the request of CMS or OHA

During the last 12-month period, has this entity had business transactions totaling more than $25,000 with a subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

During the last five years, has this entity had significant business transactions with any wholly owned supplier or subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the supplier or subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

Section IV. Disclosing entity's attestation, signature, and date

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that by knowingly providing false information on this form or in connection with any claim for payment from the State of Oregon, which may include federal funds, I may be liable for a false claim under the Oregon False Claims Act (ORS 180.750 to 180.785) and the federal False Claims Act (31 USC 3279 to 3733). I agree to inform OHA or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Name of authorized representative

Title

Signature

Date

3974 Form Information and Instructions

Do not fax these pages to OHA. Only fax pages 1 through 5 of this form.

Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security numbers (SSNs) and Dates of Birth, may be requested and used in connection with Provider enrollment and the administration of OHA medical assistance programs.

- Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program.
- Any information may also be provided to the Oregon Secretary of State, the Oregon Department of Justice including the Medicaid Fraud Unit, or other state or local agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority. Disclosures for other purposes must be authorized by law. For more information about access to information maintained by OHA, contact the Provider Services Unit.

The Authority limits its request for and use of taxpayer identification numbers, including SSNs and DOBs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits OHA to collect and use SSNs to the extent authorized by federal or state law.

Providers must submit the provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, whichever is required for tax reporting purposes on an IRS Form 1099.

Billing providers must submit the performing provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, in connection with payments made to or on behalf of the performing provider.

Providing this number is mandatory to be eligible to enroll as a provider with the Authority, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320,410-120-1260(9)(a)(B)(i)(V) and 410-141-0120 for purposes of the administration of tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.

Taxpayer identification numbers for the provider, and individuals or entities other than the provider, are also subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(A)(c), 410-120-1260, 410-120-1510(M), 410-120-1380(1)(M) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from OHA or for encounter purposes.

Definitions

Definitions for the terms that are used in this form are provided here for your convenience.

A. The source of these definitions is 42 CFR § 455.101:

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs[1], as defined by 42 CFR §455.101.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. This includes:

- An officer or director of the disclosing entity, if the entity is organized as a corporation;
- Partner in the disclosing entity, if the entity is organized as a partnership.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes

(a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
(b) any Medicare intermediary or carrier; and
(c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

[1] The following terms are defined in 42 CFR 438.2.

- Health Insuring Organization (HIO)
- Prepaid Inpatient Health Plan (PIHP)
- Managed Care Organization (MCO)
- Primary Care Case Manager (PCCM)
- Prepaid Ambulatory Health Plan (PAHP)

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

(a) has an ownership interest totaling five percent or more in a disclosing entity;
(b) has an indirect ownership interest equal to five percent or more in a disclosing entity;
(c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;
(d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;
(e) is an officer or director of a disclosing entity that is organized as a corporation; or
(f) is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

Subcontractor means

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Relationships to excluded, penalized, or convicted persons in accordance with 42 CFR §1002.3

The following terms are as defined in 42 CFR §1001.2:

- **Immediate family member** means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- **Member of household** means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Instructions for determination of ownership or control percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. The source of these definitions is 42 CFR § 455.102.

A. Indirect ownership interest

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation, which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

Person with an ownership or control interest.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Instructions for disclosing entity's signature

Signature and date stamps, or the signature of anyone other than the provider/fiscal agent, applicant, bidder, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.