

289 LaClair St • Coos Bay, OR 97420-0232 Phone 541-269-7400 • Fax 541-266-0141 Toll Free 800-264-0014

NOTICE ~Additional Information Required~

Date:

From: Advanced Health Phone: 541-269-7400
Claims Department Fax: 541-266-0141

Dear Medical Services Provider:

We have a claim for services you provided one of our members. Before payment can be made the State of Oregon, Division of Medical Assistance Programs (DMAP) requires all health care providers and suppliers enroll with the Oregon Health Plan.

Enrollment forms can be downloaded here: http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx

*Scroll down the page and click on the drop down menu titled "Select Provider Description"

- Click on your provider type from the drop down list and a listing of the required documents will be shown on the right side of the screen
- Download and complete all of the Required Forms (i.e. DMAP 3114, OHA 3972, OHA 3973) for your provider type.

Once you have completed all of the required forms, please fax these documents along with the application below and your claim(s) to 541-266-0141.

Notice: The State of Oregon, Division of Medical Assistance Programs (DMAP) now requires all health care providers and suppliers to <u>submit both Social Security Numbers and Date of Birth</u> information when initially enrolling or revalidating their participation with the Oregon Health Plan. DMAP 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.

Or Mail documents to: Advanced Health Claims Department 289 LaClair St, Coos Bay, OR 97420-0232

Thank you for your assistance.

Advanced Health Claims Department Coos Bay, Oregon 97420 Advanced Health

289 LaClair St, Coos Bay, OR 97420

Ph.: 800-264-0014 Fax: 541-266-0141

Oregon Medicaid - Provider Application (Please complete all <u>UNSHADED</u> areas)

1 Plan Name Advanced Health – Coordinate Care	2 Plan Contact Monika Vargas Gomez	
Organization - Oregon Medicaid	Data Specialist 541-269-3214	
5 Last Name First Name Initial Title	6 Business Name (if different)	
7 Physical Location Address	8 Mailing Address (if different)	
City State Zip	City St.	ate Zip
9 Area Code and Phone #	10 County	
11 Organization Sole Proprietor Corporation Other (overlain below)	12 Licensing Board	14 License Effective Date
☐ Partnership ☐ Other (explain below)	13 License Number	15 License Expiration Date
16 Provider Type 17 Effective	Date	18 Specialty
19 NPI #	20 Taxonomy Code(s)	
21 Required Identification Number Type:		
(Medical Provider) Provider's Full Name:	First MI	Loct
(HOSPITAL Only)	ıme:	Last
(Ancillary Provider)		Last
First MI Last Social Security Number of individual above:		
☐ Date of Birth of individual above:		
22 Business Tax Identification Number (FEIN):		
23 Are you an active Medicare Provider?		
24 Are you an active Medicaid Provider in another state:		
Medicaid Provider #: State:		
25 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:	