Print Clear Form

Oregon Health Authority

Division of Medical Assistance Programs

Managed Care Plan and FFS Non Paid Provider Application Instructions

Step 1. Complete each field as identified. All fields are required depending upon their applicability. NOTE: If you are a Managed Care Plan (MCP) or FFS Non Paid Provider use the Managed Care Plan (MCP) and FFS Non Paid Provider Application that follows these instruction pages.

Field	Instructions
1	Enter the name of the FFS Non Paid Provider or the MCP.
2	Enter the Plan's phone number.
3	Indicate Provider's name type by checking the appropriate box.
4	Enter the name of the Plan's Encounter Data Liaison (N/A for FFS Non Paid Provider).
5	Enter the Provider's name and title of individual or if a name of business go to field 6.
6	Enter the Provider's complete business name**.**
7	Enter the Date of Birth and Socical Security Number ***(Must match IRS records)*** for the individual identified in field 5.
8	Enter the Provider's physical address where services are provided. (***No PO Box allowed***)
9	Enter the Provider's mailing address if different from physical address.
10	Enter the Provider's phone number of business location and include area code.
11	Enter the name of the county in which the Provider's practice or service is located.
12	Enter the state that issued the license for this Provider.
13	Enter the licensing board for this Provider, as applicable.
14	Enter the Provider's professional license number as applicable.
15	Enter the Provider's effective date for the license ***(Must be equal to or earlier than the enrollment date).***
16	Enter the Provider's professional license expiration date ***(Must not precede the enrollment effective date).***
17	Indicate the proprietary nature of the Provider's business by checking the appropriate box. Please explain when "other" is indicated, using the bottom of the application.
18	Enter the Provider's Federal Employer Identification Number or Social Security Number. The Plan must enter a Social Security Number or Federal Tax ID Number, pursuant to 42 CFR §433.37, ORS 305.385, OAR 125-20-410(3) and OAR 150-305.100 for the administration of state, Federal and local tax laws.
19	Enter the Provider's tax identification number type by checking the appropriate box.
20	Enter the Provider type based on OHA's provider type list ***(See attached).***
21	Enter Provider's effective date of enrollment for Managed Care Plans and FFS Non Paid Providers ***(if the date is earlier than 6 months from the current date the Requester will be contacted by the Plan Liaison for Managed Care Plans). (FFS Non Paid Providers see field 15 and 16).***

Oregon Health Authority

Division of Medical Assistance Programs

Managed Care Plan and FFS Non Paid Provider Application Instructions

Step 1. Complete each field as identified. All fields are required depending upon their applicability. NOTE: If you are a Managed Care Plan (MCP) or FFS Non Paid Provider use the Managed Care Plan (MCP) and FFS Non Paid Provider Application that follows these instruction pages.

Field	Instructions
22	Enter the organization specialty.
23	Enter the Provider's NPI (***Must match NPPES records***).
24	Enter Provider's Taxonomy code(s) (***Must match NPPES records unless the number of taxonomy code(s) listed on NPPES exceed NPPES' maximum of 15). (Attach a sheet of paper for additional codes, if needed.)***
25	Enter the Medicare number, effective and expiration date, as applicable.
26	Enter the Medicaid number, state of issue, effective and expiration date, as applicable.
27	Ownership disclosure. Include the name and date of birth of any person with 5% or greater ownership interest in the business where services are provided ***(Go to Step 2).***

Oregon Health Authority

Division of Medical Assistance Programs

DMAP Application for Managed Care Plans Or FFS Non Paid Providers

(Read instructions before completing and submitting this page only.)

(Print or Type)

1 Provider or Plan Name	2 Provider or Plan Phone Number	
3 Name Type: ❒ Individual ❒ Business Name	4 Plan Encounter Data Liaison (if Plan representative)	
5 Name and Title	6 Business Name **(if different)**	
7 Date of Birth and Social Security Number of Individual	8 Physical Street Address	
9 Mailing Address (if different from Street Address) City State ZIP (including +4)	City State ZIP (including +4)	
10 Area Code and Phone Number	11 County	12 State Licensed Issued
17 Organization Type: ❒ Sole Proprietor ❒ Corporation ❒ Partnership ❒ Other (explain below)	13 Licensing Board 14 License Number	15 License Effective Date 16 License Expiration Date
18 Tax Identification of the Organization	19 Tax Identification Number Type: ❒ SSN (Required for Individuals) ❒ FEIN ❒ DOB (Required for Individuals)	
20 Provider Type (see attached list)	21 Effective Date of Enrollment	22 Specialty / 23 NPI Number
24 Taxonomy Code(s) (List all that are applicable) (Attach a sheet of paper for additional codes.)		
25 Are you an active Medicare Provider? ❒ Yes ❒ No (If Yes, please indicate your Medicare Provider ID number, the effective and expiration dates) Medicare Provider ID Number Medicare Effective and Expiration Dates		
26 Are you an active Medicaid Provider? ❒ Yes ❒ No (If Yes, please indicate your Medicaid Provider ID number, state of issue, the effective and expiration dates) Medicaid Provider ID # State of Issue Medicaid Effective and Expiration Dates		
27 Any person with 5% or more ownership? ❒ Yes ❒ No (If Yes, include the name of the individual(s) and their date of birth)		

OHA Provider Types

Refer to this list to enter your provider type information on page 1 of this form.

01	Transportation Provider
02	Acupuncturist
03	Alcohol/Drug
05	Ambulatory Surgical Provider
06	Behavioral Rehab Specialist
07	Billing Service
08	Freestanding Birthing Center
09	Billing Provider/Group Clinic
10	Transportation Broker
12	Copy Services
13	Cost Based Clinic
14	Rural Health Clinic
15	FQHC
16	Chiropractor
17	Dentist
18	Dental Hygienist
19	Podiatrist
20	Denturist
21	Enteral/Parenteral
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
56	Registered Nurse
57	RN 1st Assistant
58	Registered Dietician
60	Smoking Cessation
62	Education Agency
64	Targeted Case Management
65	Translator
66	Urban Clinic
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	SPD Nutritionist
83	Behavioral Consultant
84	Personal Assistant
86	SPD Nursing Services
88	Nursing Agency
89	DD Living Facilities
97	Residential Contract Rates
90	APD Living Residential
91	APD Living Settings
92	Emergency Response (Lifeline)
93	In Home Care Agency

Step 2. Complete the Department of Human Services (DHS) Electronic Data Management System (EDMS) Coversheet DHS 3970 and fax the DHS 3970 with the Division of Medical Assistance Programs (DMAP) 3108 Managed Care Plan or FFS Non Paid Provider Application. The DHS 3970 EDMS Coversheet is available on the DHS/OHA Web site at:

http://dhsforms.hr.state.or.us/Forms/Served/DE3970.pdf

a. Complete all the Requester Information (Name, Phone Number, Date and Number of pages).

b. Select the Document Type Provider Enrollment (PE).

c. In the justification line enter the words "Plan Provider Enrollment" for a managed care Plan or "Provider Enrollment" for a non paid Provider.

d. If you have initiated an enrollment via the Web portal complete the documentation identification number section.

Step 3. Fax the DHS 3970 EDMS Coversheet and the DMAP 3108 Managed Care Plans or Non Paid Provider Application to the Office of Communication Resources (OCR) at 503-378-3074.

Step 4. Complete the Ownership Disclosure Information requested below (for question 27 listed on the Application) as applicable for the completion of the enrollment process.

Ownership Disclosure Information

Name	Title	DOB	SSN	Include the ATN assigned if this is part of a Web enrollment