Provider Enrollment Disclosure Statement

For Individual Performing Providers or Individuals in a Group of Practitioners

Entities, Agencies, Facilities and Organizations: Do not use this form. Instead, use the DHS 3974 (Disclosure Statement of Ownership and Control Interest).

PURPOSE

The primary use of the Disclosure Statement is to facilitate monitoring of providers sanctioned by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), DHHS Office of Inspector General, another state, the Oregon Department of Human Services (DHS), or the Oregon Department of Justice Medicaid Fraud Unit. Payment will not be made for any services furnished by, at the medical direction of, or on the prescription of the provider, on or after the effective date of exclusion.

Completion and submission of this form is a condition of participation under any Oregon Department of Human Services' programs or as a condition of approval or renewal of a contractor agreement between the Provider and the appropriate division of DHS. Failure to submit requested information may result in a refusal by DHS to enter into a provider agreement or contract with the individual performing practitioner or in termination of existing contracts.

IDENTIFYING INFORMATION

1. Enter the provider name and location for this enrollment:

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2. Enter the nine-digit Social Security Number (SSN) or Tax Identification Number (TIN) used to report earnings for this provider:

   Attach a copy of the IRS confirmation letter showing your Tax ID number and the associated name. DHS will also accept a copy of your Federal Tax Deposit Coupon (Form 941-V).

   DHS cannot enroll individual providers without proof of their individual Tax ID number.

PROVIDER CERTIFICATIONS

Individual performing providers who not employed by or a part of another business must complete and certify the following:

1. Have you ever been sanctioned[1] or excluded[2] in any state or federal program?

   ☐ Yes ☐ No

   If yes, please explain:

2. Have you ever been disciplined[3] in any way by a professional licensing board in any state or any foreign country?

   ☐ Yes ☐ No

   If yes, please explain:

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[1] "Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

[2] "Exclusion" means that items and services furnished, order or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and any other federal or state health care program until the individual or entity is reinstated by the appropriate authority.

[3] "Disciplined" includes but is not limited to, having a license revoked, suspended, or continued under conditions which are not part of the original license (e.g., licensee may continue to practice but may not prescribe controlled substances; licensee may continue to practice but must pay restitution or other costs, attend continuing education classes, etc.).

"Disciplined" also includes revocation or surrender of a license or agreement not to have a license renewed, in exchange for a Board's agreement not to seek revocation, suspension, or conditional continuance of a license previously granted.

"Discipline" as defined in this document, is to be broadly construed.

3. Have you ever been convicted of any crime related to any public assistance, Medicare, Medicaid or Title XX programs? Includes situations involving pleas of no contest or other similar pleas upon which a judgment of conviction is entered.

☐ Yes ☐ No

If yes, please explain. Include the crime, date, and jurisdiction of conviction:

PROVIDER SIGNATURE

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, a termination of its agreement or contract.

By signing this Disclosure Statement, you hereby certify under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the Provider Services Unit or its designee, in writing, of any changes or if additional information becomes available.

Printed Name of Provider

Signature of Provider

Date

REMARKS

Provide any additional information concerning any item or statement on this Disclosure Statement:

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), may be requested and used in connection with Provider enrollment and the administration of DHS 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, including but not limited to the Oregon Public Records Act. For more information about access to information maintained by the department, contact the Provider Services Unit.

The Department limits its request for and use of taxpayer identification numbers, including SSNs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits DHS 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 Department of Human Services, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320 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)(c) 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 DHS or for encounter purposes.

Complete and return this form with the following forms and any requested documentation:

- DHS 3972 (Provider Enrollment Request)
- DHS 3975 (Provider Enrollment Agreement)
- Required Provider Enrollment Attachment (if applicable)

Send all completed provider enrollment material to:

DMAP Provider Enrollment
500 Summer St NE, E44
Salem OR 97301-1079