DHS
Oregon Department of Human Services

Print

Clear Form

Division of Medical Assistance Programs

Provider Information Update

(Please print or type)

Providers must complete this entire form for DMAP within 30 days of any change in their address, business affiliation, licensure, ownership or certification. Incomplete forms will be returned.

1. Effective date of change	2. Current Provider Number
3. Provider Name (NOTE: Box 17 must also be completed or the form will be returned)	
4. Group/Business Name (If the entity identified on line 3 is an employee or subcontractor, the information in box 17 must be completed)	
5. Physical Location Building/Suite City State ZIP	
6. Area Code - Telephone Number	Fax Number
7. Mailing Address * Building/Suite/PO Box City State ZIP	
8. E-mail Address (Optional)	9. NPI (**Attach Proof**)
10. Taxonomy Code(s)	11. EIS or SS Number (If EIN, attach copy of IRS letter) *
12. License Number (Attach copy of professional license or letter of certification)	13. Medicare/UPN Number (Attach copy of the required Medicare letter) *
14. Ownership Status (check one): ❑ Sole Proprietor ❑ Partnership ❑ Corporation ❑ Other **(explain here)**	Individual _____ _____ Group _____

15. Organization(s) authorized to bill on your behalf:

Is this billing being done by a contracted professional billing service or in-house:

Name	DMAP Number	Contracted	In-house
1._____	_____	❑	❑
2._____	_____	❑	❑
3._____	_____	❑	❑
4._____	_____	❑	❑
5._____	_____	❑	❑

Providers attach a list of additional Taxonomy Codes when no more room is available in box 10.
Individual providers must disclose in box 17 all locations where services are provided.
*** For entity identified on line 3 or 4.**

Provider Information Update

(Please print or type)

16. Do you electronically submit claims?	❑ Yes	❑ No
If "No," are you interested in acquiring information on this option?	❑ Yes	❑ No

17. To be completed by the provider listed in box 3 above. Do you work for any group other than the one identified in box 4?

❑ Yes ❑ No

If yes, you must list your other locations/employers below:

By signing below, I validate that I have indicated all locations/employers where I currently provide my service.

Provider Name (please print) **Signature** **Date**

Mail or FAX to:
DMAP Provider Enrollment
500 Summer St NE E44
Salem OR 97301-1079
FAX (503) 947-1177