Provider Enrollment Attachment

To be completed by Medical Professionals only

(Provider Name and Location for this Enrollment) (Date)

In order to enroll as a Medical Professional provider with Oregon Medicaid, you must complete this attachment and return it (along with copies of information requested) with the following information:

- Completed DHS 3972 (Provider Enrollment Request)
- Signed and dated DHS 3973 (Disclosure Statement for Individuals)
- Signed and dated DHS 3975 (Provider Enrollment Agreement)

Mental health and chemical dependency providers: Before enrolling, you must be certified by the DHS Addictions and Mental Health Division (AMH) and have a contract with AMH, a managed Mental Health Organization, or county mental health program. If you have questions about the enrollment process, call 503-947-5528 (Salem).

Identifying Information

1. Enter all current health care licensure, registrations, certificates and ID number(s), with expiration dates, on the line below and **attach a copy** of your current license(s):

Provider Type	License/Registration Number	Mo/Day/Year of Expiration
☐ Audiologist		
☐ Chiropractor		
☐ Dietician		
☐ Dispensing Optician		
☐ Home Enteral/Parenteral and IV Services		
☐ Naturopath		
☐ Nurse Anesthetist		
☐ +Nurse Practitioner		
☐ Occupational Therapist		
☐ Optometrist		
☐ Pharmacists		
☐ Physical Therapist		
☐ Physician (MD or DO)		

	☐ Physician Assistant		
	☐ Podiatrist		
	☐ Psychologist		
	☐ Public Health Clinic		
	☐ Registered Nurse (RN)		
	☐ RN First Assistant		
	☐ Speech-Language Pathologist		
	☐ Speech/Hearing Therapist		
	☐ Urban Clinic		
	☐ Other (specify):		

2. If currently or previously licensed, registered or certified in another state, territory or country, provide information about licensure, registration, certificates and ID numbers, with expiration dates. If the license, certificate or registration was surrendered or not renewed, explain the reason.

Type	**State/Country**	**License/ registration number**	**Mo/Day/Year of Expiration/ Surrender**	**Reason, if surrendered or not renewed**

3. List any current or previous DHS Provider Numbers here:

4. List any names/business names currently or previously used with DMAP or other Department of Human Services contract:

5. Are you employed by a unit of government when providing these services? Check any government type that applies to this provider.

☐ County ☐ School district ☐ Transportation district

☐ State ☐ Special purpose district ☐ Tribal

☐ Publicly operated teaching hospital ☐ Other governmental unit (specify):

Insurance Information

1. List the professional liability insurance information you have, will maintain, and will provide upon request by DHS or a DHS designee. This is to cover damages caused by error, omission or negligent acts related to the professional services to be provided as an Oregon Medicaid provider.

   If you cancel, materially change, reduce limits, or intend not to renew the insurance coverage(s) listed below, you must notify DMAP within 30 days of the change**:**

Carrier Name	Policy Number	Expiration Date	Amount insured per occurrence

2. If you are self-insured for these insurance requirements, enter "Self-Insured" here:

Out-of-State Providers only:

In addition to the information requested above, provide the following information:

1. Enter the name and telephone number of the Medicaid office in the state in which your practice is located that can confirm your Medicaid enrollment in that state:

Medicaid Office Name	Phone Number

2. **Attach a copy** of all licenses and certificates showing authority to practice medicine for the state in which your practice is located.