Provider Enrollment Attachment

to be completed by Transportation Providers only

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

In order to enroll as a Transportation Provider that is paid by 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 3974 (Disclosure Statement of Ownership and Control Interest)
- Signed and dated DHS 3975 (Provider Enrollment Agreement)

If you receive payment from a Transportation Brokerage, do not fill out this enrollment for transportation services provided through the brokerage.

Identifying Information

1. Check the type(s) of service you provide. For each type of service you provide, list the counties in which you do business. If local approval authority is required to do business, enter the certificate(s) or other approval numbers that document local authority to operate.

   Attach a copy of any licenses, certificates or other authority (including local jurisdiction authority) required by law to provide the service.

Provider Type	Counties Served	Certificate/ Approval Number(s)
☐ Air ambulance		
☐ Ambulance		
☐ Brokerage		
☐ Neonatal Intensive		
☐ Stretcher Car		
☐ Taxi		
☐ Wheelchair Van		
☐ Other transportation service (specify):		

2. If you are enrolling as a taxi, enter your taximeter number(s) here:

3. If you are requesting a Transportation Provider number for a business entity, please complete the following:

   # of Company Vehicles: # of Driver Owned Vehicles:

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

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

6. Is the provider owned or operated by a unit of government? 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):

7. If applicable, list your rates here and **attach a copy** of your fee schedule:

Insurance Information

1. List the general and 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 the provider 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 operate in Oregon and in the state in which the provider is located.

   Note: Ambulance service providers located in a contiguous state which regularly provides transports for DHS clients must be licensed by both the Oregon Health Division and the state in which the provider is located.