



## Provider Enrollment Attachment

To be completed by Chemical Dependency Providers only

\_\_\_\_\_  
(Provider Name and Location for this Enrollment)

\_\_\_\_\_  
(Date)

In order to enroll as a Chemical Dependency provider, 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)

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. Check the type(s) of service you provide. For each type of service you provide, enter your current business/facility license number or letter of approval issued by the DHS Addictions and Mental Health (AMH).

**Attach a copy** of your current license or letter of approval from AMH for each service selected below. Each license type at the location for this application must be specifically identified.

| Provider Type                                                            | License/Approval Number(s) |
|--------------------------------------------------------------------------|----------------------------|
| <input type="checkbox"/> Alcohol and drug acupuncture clinic             |                            |
| <input type="checkbox"/> Alcohol and drug evaluation specialist          |                            |
| <input type="checkbox"/> Detoxification                                  |                            |
| <input type="checkbox"/> DUII alcohol/other drug information program     |                            |
| <input type="checkbox"/> DUII alcohol/other drug rehabilitation program  |                            |
| <input type="checkbox"/> Substance abuse treatment program – Inpatient   |                            |
| <input type="checkbox"/> Substance abuse treatment program – Outpatient  |                            |
| <input type="checkbox"/> Synthetic opiate treatment program – Outpatient |                            |

|                                                                   |  |
|-------------------------------------------------------------------|--|
| <input type="checkbox"/> Residential treatment program – Children |  |
| <input type="checkbox"/> Other licensed category (specify):       |  |

2a. Enter your laboratory’s CLIA number and **attach a copy** of your current CLIA Certification letter:

2b. If your program contracts for laboratory services, complete the following and **attach a copy** of the certification letter:

Laboratory Name:

Laboratory’s CLIA number:

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. Is the chemical dependency provider owned or operated by a unit of government? Check any government type that applies to this provider.

- |                                 |                                                              |                                                             |
|---------------------------------|--------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> County | <input type="checkbox"/> School district                     | <input type="checkbox"/> Transportation district            |
| <input type="checkbox"/> State  | <input type="checkbox"/> Special purpose district            | <input type="checkbox"/> Tribal                             |
| <input type="checkbox"/> City   | <input type="checkbox"/> Publicly operated teaching hospital | <input type="checkbox"/> 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 |
|--------------|---------------|-----------------|-------------------------------|
|              |               |                 |                               |
|              |               |                 |                               |
|              |               |                 |                               |

|  |  |  |  |  |
|--|--|--|--|--|
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|--|--|--|--|--|

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 the program type(s) identified above for the state in which the provider is located.