289 LaClair St • Coos Bay, OR 97420-0232
Phone 541-269-7400 • Fax 541-266-0141
Toll Free 800-264-0014

NOTICE
~Additional Information Required~

Date:

From: Advanced Health
Claims Department

Phone: 541-269-7400
Fax: 541-266-0141

Dear Medical Services Provider:

We have a claim for services you provided one of our members. Before payment can be made the State of Oregon, Division of Medical Assistance Programs (DMAP) requires all health care providers and suppliers enroll with the Oregon Health Plan.

Enrollment forms can be downloaded here:
http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx

**Scroll down the page and click on the drop down menu titled "Select Provider Description"*

- Click on your provider type from the drop down list and a listing of the required documents will be shown on the right side of the screen
- Download and complete all of the Required Forms (i.e. DMAP 3114, OHA 3972, OHA 3973) for your provider type.

Once you have completed all of the required forms, please fax these documents along with the application below and your claim(s) to 541-266-0141.

Notice: *The State of Oregon, Division of Medical Assistance Programs (DMAP) now requires all health care providers and suppliers to submit both Social Security Numbers and Date of Birth information when initially enrolling or revalidating their participation with the Oregon Health Plan. DMAP is taking this action as required under Section 6401 of the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010. The CMS final rule addressing Section 6401 of the PPACA is CMS-6028-FC.*

Or Mail documents to:
Advanced Health
Claims Department
289 LaClair St, Coos Bay, OR 97420-0232

Thank you for your assistance.

Advanced Health
Claims Department
Coos Bay, Oregon 97420

Advanced Health
289 LaClair St, Coos Bay, OR 97420
Ph.: 541-269-7400 Toll: 800-264-0014
Fax: 541-266-0141

Oregon Medicaid - Provider Application

*(Please complete all **UNSHADED** areas)*

1 Plan Name: Advanced Health – Coordinate Care Organization Oregon Medicaid	2 Plan Contact: Claims Department 541-269-0567
5 Last Name First Name Initial Title	6 Business Name (if different)
7 Physical Location Address	8 Mailing Address (if different)
City State Zip	City State Zip
9 Area Code and Phone #	10 County
11 Organization ☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other (explain below)	12 Licensing Board / 14 License Effective Date 13 License Number / 15 License Expiration Date
16 Provider Type / 17 Effective Date	18 Specialty
19 NPI #	20 Taxonomy Code(s)

21 Required Identification Number Type:

(Medical Provider) ☐ Provider's Full Name: ______________________________
First MI Last

(HOSPITAL Only) ☐ Hospital Administrators Full Name: ______________________________
First MI Last

(Ancillary Provider) ☐ Owner/Administrators Name: ______________________________
First MI Last

☐ Social Security Number of individual above: ______________________________

☐ Date of Birth of individual above: ______________________________

22 Business Tax Identification Number (FEIN):

23 Are you an active Medicare Provider? ☐ Yes ☐ No
(If Yes, please indicate your Medicare Provider ID Number) Medicare Provider ID: ______________________

24 Are you an active Medicaid Provider in another state: ☐ Yes ☐ No
(If Yes, please indicate your Medicaid Provider ID number and State)
Medicaid Provider #: ______________________________ State: ______________________

25 **Are there any persons with 5% or more ownership**: ☐ Yes ☐ No
(If Yes, please include the name of the individual(s) and their date of birth. Attach another page if necessary.)

Name: ____ Date of Birth: ____/____/______

Name: ____ Date of Birth: ____/____/______

Name: ____ Date of Birth: ____/____/______

Please fax completed application and your claim back to: Advanced Health at 541-266-0141.