DHS Oregon Department of Human Services

EDMS COVERSHEET

Use to fax documents for entry into the Oregon Medicaid Electronic Document Management System (EDMS).

Oregon Health Authority

From: _____ **Date:** _____

Phone: _____ **No. of Pages:** _____
(including this coversheet)

Document Type: Check only one box and fax to the number shown. Use a new coversheet for each transaction.

- ☒ Provider Enrollment (PE) - 503-378-3074
- ☐ Claim Documentation - 503-378-3086
- ☐ Prior Authorization (PA)

For PA requests, also check one box below:

- ☐ Routine Processing - 503-378-5814
- ☐ Urgent Processing *(72 hours)*
- ☐ Immediate Processing *(24 hours)*

} 503-378-3435

- ☐ Hearing Documentation *(no central fax #)*
- ☐ Grievance Documentation *(no central fax #)*
- ☐ Correspondence - 503-378-3086

Justification and additional documentation is required for Urgent or Immediate processing *(summarize below)*. If your PA request does not meet Urgent or Immediate criteria, it will receive Routine processing.

Justification: _____

_____

For Provider Enrollment requests: Find required forms and instructions at: www.oregon.gov/OHA/HSD/OHP/Pages/Provider-Enroll.aspx

For Prior Authorization requests and claim documentation: Find program-specific PA criteria and documentation requirements at www.oregon.gov/OHA/HSD/OHP/Pages/Policies.aspx *(click on the link for your program)*.

Documentation Identification Numbers: Provider ID is required on all requests from providers. To link documents to a specific Recipient ID, PA, claim or other record in our system, enter the appropriate number(s) below. Use one character or number per box; press tab between each entry.

PE Application Tracking Number (ATN): ☐☐☐☐☐☐☐☐☐☐

Provider ID *(NPI or Oregon Medicaid ID)*: ☐☐☐☐☐☐☐☐☐☐☐

Recipient ID *(as listed on the Medical ID)*: ☐☐☐☐☐☐☐☐☐

Prior Authorization Number (PAN): ☐☐☐☐☐☐☐☐☐☐☐

Internal Claim Number (ICN): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Hearings/Grievances Number (HGN): ☐☐☐☐☐☐☐☐☐☐

Contact Tracking Number (CTN)*: ☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐

**For DHS/OHA staff use only: Enter the CTN to link correspondence to a specific Contact Tracking Management System (CTMS) entry. Include CTMS question number and notes number, as applicable. If the CTN is linked to a specific provider or recipient contact, also enter the Provider or Recipient ID.*

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Provider Information Update Form

Complete this form within 30 days of any change in your address, business affiliation, licensure or certification (OAR 410-120-1260). Complete all fields as applicable. Fax under an EDMS Coversheet to 503-378-3074 (Salem).

To report an ownership change, do not use this form.
Contact Provider Enrollment at 800-336-6016 (Option 6) to find out what forms you need to complete.

The update request is for:

☐ Individual Provider	☐ Organization
Oregon Medicaid ID (MCD):	National Provider Identifier (NPI):
Effective date for these changes:	

Complete this section for an individual provider:

Last name	First name	Middle initial
Date of birth:	SSN:	Medicare ID (PTAN):
License/certification number:	License effective date:	
Licensing Board:	License expiration date:	

Organization(s) that bill on your behalf – *Attach list if more space is needed.*

Primary location name: The location the provider serves most of the time.	**MCD or NPI**
Secondary location name(s): List locations in priority order.	**MCD or NPI**

Complete this section for an organization, group or agency:

Business Name (legal business name, include DBA if applicable):			
Federal Employer Identification Number (FEIN):			
Organization Type:	☐ Sole Proprietor	☐ Corporation	☐ Partnership
	☐ LLC	☐ Government	☐ Non-Profit
	☐ Other **(explain here):**		

Address changes

Service location

Enter the service or location address where services are rendered. Address must be a physical street address (not a PO Box).

Physical address (include Room/Suite):		City, State, ZIP+4 Code:
County:	Phone (include area code):	Fax (include area code):

Mail-To address

Enter only if the address is different from the service location address:

Street or PO Box (include Room/Suite):	City, State, ZIP+4 Code:

Pay-To address

Enter only if different from the Mail-To address:

Street or PO Box (include Room/Suite):	City, State, ZIP+4 Code:

Contact information

Contact person name:	Contact phone:
Contact email:	Contact fax:

Taxonomy code changes – *Attach a separate sheet if more space is needed.*

Primary:		Description:	
Secondary:		Description:	
Other:		Description:	

Signature

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.

Provider or authorized representative signature	Name (please print or type)	Date