HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Print

Clear Form

Provider Enrollment Information

Complete all applicable information.

Individual provider information

Last name: First name: Middle initial:

Date of birth (DOB):

Social Security number (SSN):

Title/Degree *(as appears on license):*

IRS Tax ID type *(for reporting purposes for payment; check one):* This information must match IRS's information on file.

☐ SSN ☐ DOB

Group Practice: If you are applying to join an existing group, enter the group's NPI(s).

Group/facility information

Group/Facility name:

Doing Business As (DBA) name:

Business IRS Tax ID *(for reporting purposes for payment):* This information must match IRS's information on file.

Business name associated with IRS FEIN:	FEIN

Enrollment information

Business type *(check all that apply):*

☐ Individual Practitioner ☐ Chain ☐ Trust

☐ Sole Proprietorship ☐ Government ☐ LLC

☐ Partnership ☐ Intergovernmental ☐ LLP

☐ Business Corporation: ☐ For profit ☐ Non-Profit

☐ Private: ☐ For profit ☐ Non-Profit

Are you applying as a *(select one):*

☐ Individual ☐ Group ☐ Facility ☐ Organization

Identification Numbers:

DEA Number:	EFT Number:	NPI:
NABP Number:	CDS (Controlled Dangerous Substance) Number:	

Provider Type: Select the provider type you are requesting enrollment as.

- ☐ Acupuncturist (02)
- ☐ Advance Practice Nurse (42)
- ☐ Advanced Comprehensive Health Care (Naturopath) (38)
- ☐ Alcohol/Drug (03)
- ☐ Ambulatory Surgical Provider (05)
- ☐ Behavioral Consultant (83)
- ☐ Behavioral Rehab Specialist (06)
- ☐ Billing Provider/Group Clinic (09)
- ☐ Billing Service (07)
- ☐ Certified Registered Nurse Anesthetist (37)
- ☐ Chiropractor (16)
- ☐ Dental Hygienist (18)
- ☐ Dentist (17)
- ☐ Denturist (20)
- ☐ DME/Medical Supply Dealer (36)
- ☐ Education Agency (62)
- ☐ Emergency Response (Lifeline) (92)
- ☐ End-Stage Renal Disease Clinic (32)
- ☐ Enteral/Parenteral (21)
- ☐ Family Planning Clinic (22)
- ☐ FQHC (15)
- ☐ Freestanding Birthing Center (08)
- ☐ Habilitation (78)
- ☐ Hearing Aid Dealer (23)
- ☐ Home Health Agency (24)
- ☐ Hospice (27)
- ☐ Hospital (26)
- ☐ Independent Labs (29)
- ☐ Indian Health Clinics (28)
- ☐ Mental Health Personal Care Attendant (30)
- ☐ Mental Health Provider (33)
- ☐ Midwife (41)
- ☐ Optician (44)
- ☐ Optometrist (43)
- ☐ Oregon State Hospital (35)
- ☐ Pharmacist (50)
- ☐ Pharmacy (48)
- ☐ Physician (34)
- ☐ Physician Assistants (46)
- ☐ Podiatrist (19)
- ☐ Polygrapher (54)
- ☐ Prenatal Clinic (49)
- ☐ Psychologist (53)
- ☐ Public Health Clinic (47)
- ☐ Registered Dietician (58)
- ☐ Registered Nurse (56)
- ☐ RN 1st Assistant (57)
- ☐ Rural Health Clinic (14)
- ☐ Smoking Cessation (60)
- ☐ Targeted Case Management (64)
- ☐ Therapist (45)
- ☐ Transportation Provider (01)
- ☐ X-Ray Clinic (52)

Specialty Information: List below. *If you have additional specialty/taxonomies, please list on an attachment (maximum allowed is 15).*

Primary Specialty:	Taxonomy:		
Sub-Specialty:	Taxonomy:	Effective Date:	End Date:
Sub-Specialty:	Taxonomy:	Effective Date:	End Date:
Sub-Specialty:	Taxonomy:	Effective Date:	End Date:
Sub-Specialty:	Taxonomy:	Effective Date:	End Date:
Sub-Specialty:	Taxonomy:	Effective Date:	End Date:

License/Certification Information:

License Number:	License Type:	Certification:
Begin Date:	End Date:	State:

Are you an active Medicare Provider? *If Yes, please indicate your Medicare Provider ID number.* ☐ Yes ☐ No

Medicare Provider ID number:

Are you an active Medicaid Provider in another state? *If Yes, please indicate your Medicaid Provider ID number, state and contact information.* ☐ Yes ☐ No

Other State Medicaid Provider ID	State of Issue	
State Contact Name	Email	Phone Number

Provider address 1. Complete all applicable information. ***Note:*** *A post office box is not a valid service location; the service location address must be a physical street address.*

Street address (include Room/Suite):	City, State, ZIP:	Information applies to *(check all that apply):* ☐ Service Location ☐ Pay-To ☐ Mail-To ☐ Home Office ☐ Corporate Office ☐ Medical Information ☐ Personal Residence
County:	Business Phone:	Toll-Free Phone:
Fax Number:	Cell Phone:	E-mail:
International Phone:	International Fax:	ADA Accessible? ☐ Yes ☐ No

Contact Name:	Contact SSN:	Contact DOB:
Contact Title:	Contact Type:	

Contact E-mail:	Contact Phone Number:	Contact Cell Phone Number:
Contact Fax Number:	Contact Effective Date:	Contact End Date:

If this information applies to more than one service location, list the service locations here:

Provider address 2. Complete all applicable information. If you need to provide more than two addresses, please list on an attachment. ***Note:*** *A post office box is not a valid service location; the service location address must be a physical street address.*

Street or PO Box (include Room/Suite):	City, State, ZIP:	Information applies to *(check all that apply):* ☐ Service Location ☐ Pay-To ☐ Mail-To ☐ Home Office ☐ Corporate Office ☐ Medical Information ☐ Personal Residence
County:	Business Phone:	Toll-Free Phone:
Fax Number:	Cell Phone:	E-mail:
International Phone:	International Fax:	ADA Accessible? ☐ Yes ☐ No

Contact Name:	Contact SSN:	Contact DOB:
Contact Title:	Contact Type:	
Contact E-mail:	Contact Phone Number:	Contact Cell Phone:
Contact Fax Number:	Contact Effective Date:	Contact End Date:

If this information applies to more than one service location, list the service locations here:

Internal Use Only: ATN