

## 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 _____
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### Enrollment information

**Business type** (*check all that apply*):

Individual Practitioner

Chain

Trust

Sole Proprietorship

Government

LLC

Partnership

Intergovernmental

LLP

Business Corporation:

Private:

For profit  Non-Profit

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.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acupuncturist (02)                                   | <input type="checkbox"/> Enteral/Parenteral (21)                    | <input type="checkbox"/> Pharmacist (50)               |
| <input type="checkbox"/> Advance Practice Nurse (42)                          | <input type="checkbox"/> Family Planning Clinic (22)                | <input type="checkbox"/> Pharmacy (48)                 |
| <input type="checkbox"/> Advanced Comprehensive Health Care (Naturopath) (38) | <input type="checkbox"/> FQHC (15)                                  | <input type="checkbox"/> Physician (34)                |
| <input type="checkbox"/> Alcohol/Drug (03)                                    | <input type="checkbox"/> Freestanding Birthing Center (08)          | <input type="checkbox"/> Physician Assistants (46)     |
| <input type="checkbox"/> Ambulatory Surgical Provider (05)                    | <input type="checkbox"/> Habilitation (78)                          | <input type="checkbox"/> Podiatrist (19)               |
| <input type="checkbox"/> Behavioral Consultant (83)                           | <input type="checkbox"/> Hearing Aid Dealer (23)                    | <input type="checkbox"/> Polygrapher (54)              |
| <input type="checkbox"/> Behavioral Rehab Specialist (06)                     | <input type="checkbox"/> Home Health Agency (24)                    | <input type="checkbox"/> Prenatal Clinic (49)          |
| <input type="checkbox"/> Billing Provider/Group Clinic (09)                   | <input type="checkbox"/> Hospice (27)                               | <input type="checkbox"/> Psychologist (53)             |
| <input type="checkbox"/> Billing Service (07)                                 | <input type="checkbox"/> Hospital (26)                              | <input type="checkbox"/> Public Health Clinic (47)     |
| <input type="checkbox"/> Certified Registered Nurse Anesthetist (37)          | <input type="checkbox"/> Independent Labs (29)                      | <input type="checkbox"/> Registered Dietician (58)     |
| <input type="checkbox"/> Chiropractor (16)                                    | <input type="checkbox"/> Indian Health Clinics (28)                 | <input type="checkbox"/> Registered Nurse (56)         |
| <input type="checkbox"/> Dental Hygienist (18)                                | <input type="checkbox"/> Mental Health Personal Care Attendant (30) | <input type="checkbox"/> RN 1st Assistant (57)         |
| <input type="checkbox"/> Dentist (17)   | <input type="checkbox"/> Mental Health Provider (33)                | <input type="checkbox"/> Rural Health Clinic (14)      |
| <input type="checkbox"/> Denturist (20)                                       | <input type="checkbox"/> Midwife (41)                               | <input type="checkbox"/> Smoking Cessation (60)        |
| <input type="checkbox"/> DME/Medical Supply Dealer (36)                       | <input type="checkbox"/> Optician (44)                              | <input type="checkbox"/> Targeted Case Management (64) |
| <input type="checkbox"/> Education Agency (62)                                | <input type="checkbox"/> Optometrist (43)                           | <input type="checkbox"/> Therapist (45)                |
| <input type="checkbox"/> Emergency Response (Lifeline) (92)                   | <input type="checkbox"/> Oregon State Hospital (35)                 | <input type="checkbox"/> Transportation Provider (01)  |
| <input type="checkbox"/> End-Stage Renal Disease Clinic (32)                  |   | <input type="checkbox"/> 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 ( <i>check all that apply</i> ): <input type="checkbox"/> Service Location <input type="checkbox"/> Pay-To <input type="checkbox"/> Mail-To <input type="checkbox"/> Home Office <input type="checkbox"/> Corporate Office <input type="checkbox"/> Medical Information <input type="checkbox"/> Personal Residence
County:	Business Phone:	Toll-Free Phone:		
Fax Number:	Cell Phone:	E-mail:		
International Phone:	International Fax:	ADA Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( <i>check all that apply</i> ): <input type="checkbox"/> Service Location <input type="checkbox"/> Pay-To <input type="checkbox"/> Mail-To <input type="checkbox"/> Home Office <input type="checkbox"/> Corporate Office <input type="checkbox"/> Medical Information <input type="checkbox"/> Personal Residence
County:	Business Phone:	Toll-Free Phone:		
Fax Number:	Cell Phone:	E-mail:		
International Phone:	International Fax:	ADA Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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***Internal Use Only: ATN***