



# EDMS COVERSHEET

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



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.

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Provider Enrollment (PE) - 503-378-3074 | <input type="checkbox"/> Hearing Documentation (no central fax #)   |
| <input type="checkbox"/> Claim Documentation - 503-378-3086                 | <input type="checkbox"/> Grievance Documentation (no central fax #) |
| <input type="checkbox"/> Prior Authorization (PA)                           | <input type="checkbox"/> Correspondence - 503-378-3086              |
- For PA requests, also check one box below:*
- |  |                |
|--|----------------|
| <input type="checkbox"/> Routine Processing - 503-378-5814 | } 503-378-3435 |
| <input type="checkbox"/> Urgent Processing (72 hours)      |                |
| <input type="checkbox"/> Immediate Processing (24 hours)   |                |

**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:** DMAP 3113 Non-Payable Entity

**For Provider Enrollment requests:** Find required forms and instructions at [www.oregon.gov/OHA/healthplan/pages/providerenroll.aspx](http://www.oregon.gov/OHA/healthplan/pages/providerenroll.aspx).

**For Prior Authorization requests and claim documentation:** Find program-specific PA criteria and documentation requirements at [www.oregon.gov/OHA/healthplan/pages/policies.aspx](http://www.oregon.gov/OHA/healthplan/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.*

**Confidentiality Notice:** The information contained in this packet is confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax - except its direct delivery to the intended recipient - is strictly prohibited. If you have received this packet in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

## Non-Payable Provider Enrollment Form

Use this form to enroll providers with Oregon Medicaid for reasons other than direct reimbursement. Fax the completed form to 503-378-3074 (Salem) under a completed EDMS Coversheet ([MSC 3970](#)). Complete a new form and coversheet for each provider you need to enroll.

Fields with an asterisk (\*) are required, if applicable, on **all** requests. Failure to complete all required fields will delay processing.

### Individual provider information

|   |             |   |
|---|-------------|---|
| Last name*  | First name* | Middle initial*   |
| Date of birth*:                                   |             | SSN*:   |
| NPI*:<br><i>Complete only if eligible for NPI</i> |             | Medicare ID (PTAN)*:<br><i>Complete only if enrolled as a Medicare provider</i> |
| License/certification number*:                    |             | License/cert. effective date*:  |
| Licensing/certification board*:                   |             | License/cert. expiration date*:   |

### Address information

**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: |
|--|--------------------------|

### Medicaid enrollment information

|   |  |
|---|--|
| Out-of-State Medicaid Provider ID*:   | State of issue*:   |
| <i>Non-Oregon providers must be actively enrolled in their own state before they can enroll with Oregon Medicaid. Complete this section only if you are not an Oregon provider.</i> |  |
| Oregon Medicaid provider type*:   | <i>Enter the 2-digit code for this request (see page 3 for codes).</i> |
| <b>Taxonomy code*</b> – <i>Attach a separate sheet if more space is needed:</i>   |  |
| Primary*:   | Description:   |
| Secondary:  | Description:   |
| Other:  | Description:   |

**Behavioral Health (Type 33) Specialty:** *See list on page 3.*

Enter specialty code: \_\_\_\_\_

**Traditional Health Worker (Type 13) Specialty:** *See list on page 3.*

Enter specialty code: \_\_\_\_\_

**Group affiliation** – *Provide the following information for the group, clinic, organization, agency, or outpatient program that is requesting enrollment of the enrolling provider.*

Legal business name\*:

NPI\*:

Oregon Medicaid ID\*:

**Contact name\*:** \_\_\_\_\_

*This is the person we will contact if we have questions about this enrollment request.*

Contact email (*please print or type*)\*:

Contact phone number\*:

Contact fax number\*:

### Enrollment request information

Effective date requested for this enrollment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*The effective date cannot be older than 1 year from the date of receipt. If this field is blank, the effective date will be the date we received your application.*

### 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

## Oregon Medicaid provider types and specialty codes

Refer to this list to enter the 2-digit provider type and 3-digit specialty code on page 1 of this form.

|  |  |
|--|--|
| 02 – Acupuncturist   |  |
| 45 – Audiologist   |  |
| 06 – Behavior Rehabilitation Specialist                                    |  |
| 33 – Behavioral Health Practitioner. Specialty codes:                      |  |
| 376 – Applied Behavioral Analysis (ABA) Behavioral Analyst Interventionist | 372 - LPC                                |
| 375 – ABA Board-Certified assistant Behavior Analyst (BCaBA)               | 365 - PMHNP                              |
| 374 – ABA Board-Certified Behavioral Analyst (BCBA)                        | 227 - Psychiatrist                       |
| 378 – ABA Professional pending BARB registration                           | 205 - Psychologist                       |
| 448 - Community Habilitation employee                                      | 209 - QMHA                               |
| 206 - LCSW   | 209 - QMHP                               |
| 371 - LFMT   | 314 - Student intern                     |
| 16 – Chiropractor  |  |
| 17 – Dentist   |  |
| 18 – Dental Hygienist  |  |
| 20 – Denturist   |  |
| 44 – Dispensing Optician   |  |
| 23 – Hearing Aid Dealer  |  |
| 69 – Licensed Clinical Social Worker (for administrative exams only)       |  |
| 41 – Licensed Direct Entry Midwife   |  |
| 21 – Medical Electrolysis Provider   |  |
| 38 – Naturopath  |  |
| 37 – Nurse Anesthetist   |  |
| 42 – Nurse Practitioner (Advance Practice Nurse)                           |  |
| 45 – Occupational Therapist  |  |
| 43 – Optometrist   |  |
| 17 – Oral Surgeon (Dental)   |  |
| 50 – Pharmacist. Specialty code:   |  |
| 109 – Hormonal Birth Control Prescriber                                    |  |
| 45 – Physical Therapist  |  |
| 34 – Physician (MD or DO)  |  |
| 46 – Physician Assistant   |  |
| 19 – Podiatrist  |  |
| 54 – Polygrapher   |  |
| 53 – Psychologist (for administrative exams only)                          |  |
| 58 – Registered Dietician  |  |
| 57 – RN First Assistant  |  |
| 45 – Speech and Hearing Therapist  |  |
| 45 – Speech-Language Pathologist   |  |
| 03 – Substance Use Disorder Counselor                                      |  |
| 13 – Traditional Health Worker. Specialty codes:                           |  |
| 600 – Doula  | 606 – Peer support, family               |
| 601 – Community health worker  | 607 – Peer support, youth                |
| 602 – Navigator  | 608 – Peer wellness, adult addictions    |
| 603 – Certified recovery mentor  | 609 – Peer wellness, adult mental health |
| 604 – Peer support, adult addictions                                       | 610 – Peer wellness, family              |
| 605 – Peer support, adult mental health                                    | 611 – Peer wellness, youth               |