Provider Information Form

To ensure prompt and accurate claims payment, please complete the following form.
You may e-mail the completed form to your CareOregon Network Relations Associate, or fax it to 503-416-1478

CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

Date:_____

Practice/Group/Facility name:_____ **Specialty:**_____

Name of person completing this form:_____ **Phone (with area code):**_____

Ownership Disclosure Information

Owner's name (must have at least 5% ownership)	**Title of Owner**	**Owner's DOB**	**Owner's SSN**

Practice Location Addresses:

(*print locations' street address, **NOT** a P.O. box. If your practice has more than three locations, use more pages*)

LOCATION #1

Tax ID number:_____ **Location NPI (10-digits):**_____ **Clinic Taxonomy code(s):**_____

Clinic Manager/Administrator:_____ Title:_____

E-mail:_____ Hours of operation:_____

Street address:_____ Suite number:_____ County:_____

City:_____ State:_____ ZIP code (9 digits):_____ Phone:_____

Fax:_____ Do you receive mail at this address? YES☐ NO☐ If not, where do you want the mail sent?

Mailing address:_____ Suite number:_____

City:_____ State:_____ ZIP code (9 digits):_____ County:_____

Do you want payment for this location mailed to this address? YES☐ NO☐ If not, where do you want us to mail payments for this location?

Billing address:_____ Suite number:_____

City:_____ State:_____ ZIP code (9 digits):_____ County:_____

LOCATION #2

Tax ID number:_____ **Location NPI (10-digits):**_____ **Clinic Taxonomy code(s):**_____

Clinic Manager/Administrator:_____ Title:_____

E-mail:_____ Hours of operation:_____

Street address:_____ Suite number:_____ County:_____

City:_____ State:_____ ZIP code (9 digits):_____ Phone:_____

Fax:_____ Do you receive mail at this address? YES☐ NO☐ If not, where do you want the mail sent?

Mailing address:_____ Suite number:_____

City:_____ State:_____ ZIP code (9 digits):_____ County:_____

Do you want payment for this location mailed to this address? YES☐ NO☐ If not, where do you want us to mail payments for this location?

Billing address:_____ Suite number:_____

City:_____ State:_____ ZIP code (9 digits):_____ County:_____

LOCATION #3

Tax ID number:_____ **Location NPI (10-digits):**_____ **Clinic Taxonomy code(s):**_____

Clinic Manager/Administrator:_____ Title:_____

E-mail:_____ Hours of operation:_____

Street address:_____ Suite number:_____ County:_____

City:_____ State:_____ ZIP code (9 digits):_____ Phone:_____

Fax:_____ Do you receive mail at this address? YES☐ NO☐ If not, where do you want the mail sent?

Mailing address:_____ Suite number:_____

City:_____ State:_____ ZIP code (9 digits):_____ County:_____

Do you want payment for this location mailed to this address? YES☐ NO☐ If not, where do you want us to mail payments for this location?

Billing address:_____ Suite number:_____

City:_____ State:_____ ZIP code (9 digits):_____ County:_____

Individual Providers

(Use more pages if necessary) PLEASE NOTE: Facilities (i.e. hospitals, SNFs or hospice) do not need to complete this section)

PROVIDER #1

Name:_____ Professional degree:_____

NPI (10-digits):_____ Provider taxonomy code(s):_____ DMAP ID*:_____ SSN:_____

Specialty:_____ Gender M:_____ F:_____ Date of Birth:_____

Professional License #:_____ Languages spoken (other than English):_____

Check location number(s) where this practitioner sees patients: 1:_____ 2:_____ 3:_____ 4:_____ 5:_____ 6:_____ 7:_____ 8:_____ 9:_____ 10:_____

PROVIDER #2

Name:_____ Professional degree:_____

NPI (10-digits):_____ Provider taxonomy code(s):_____ DMAP ID*:_____ SSN:_____

Specialty:_____ Gender M:_____ F:_____ Date of Birth:_____

Professional License #:_____ Languages spoken (other than English):_____

Check location number(s) where this practitioner sees patients: 1:☐ 2:☐ 3:☐ 4:☐ 5:☐ 6:☐ 7:☐ 8:☐ 9:☐ 10:☐

**If no DMAP ID, CareOregon can request on provider's behalf, but SSN and Date of Birth are required in order to request.*

Credentialing Contact Information

Name:_____ E-mail:_____

Address:_____ Phone:_____