PROVIDER INTEREST FORM

Provider Contracting
PO Box 7068
Springfield, OR 97475
Fax: (541) 225-3643

Please print legibly and complete in full. Return completed form to your Provider Contracting Representative.

PROVIDER / GROUP INFORMATION				
Provider name			Degree/title	
Practice name/facility			Practice effective date	
Specialty			Specialty effective date	Specialty expiration date
Clinic contact			Name as it appears on your W-9	
Email			Language fluency	
Contract line of business requested	☐ Commercial	☐ Coordinated care	☐ Medicare (must have active PTAN number)	☐ Medicaid (must have active DMAP number)

PROVIDER ID NUMBERS			
License	State	Effective	Expires
DEA		Effective	Expires
NPI		TIN/SSN (whichever you are using to bill)	
Medicare		Effective	
DMAP		Effective	

PRACTICE / PHYSICAL LOCATION			
Street address			
City	State	County	Zip code
Phone		Fax	Effective date

PAY TO / MAILING INFORMATION (☐ check if same as above)			
Street address			
City	State	County	Zip code
Phone		Fax	Effective date
Billing contact name		Billing contact phone	Billing contact email
Credentialing contact name		Credentialing contact phone	Credentialing contact email

FORM COMPLETED BY	
Signature	Date
Print name	Contact number
Email	