Provider Information Form

Fill out the information below for providers who are new to contracting with CareOregon and need to be added to our provider database. To ensure prompt and accurate claims payment, please complete the below form and email to your Provider Relations Specialist.

CareOregon®

Credentialing Contact Information

Name: _____ Email: _____

Address: _____ Phone#: _____

Practice Information

Practice name: _____

Primary office address 1: _____ Location NPI (type 2): _____

Office address 2: _____ Location NPI (type 2): _____

Office address 3: _____ Location NPI (type 2): _____

Primary office phone: _____ Primary office fax: _____

Practice/office manager name: _____

Practice/office manager phone: _____

Primary mailing street address: _____

City: _____ State: _____ ZIP: _____

Primary billing address: _____

City: _____ State: _____ ZIP: _____

TIN/EIN: _____ Billing phone: _____ Billing fax: _____

Does your clinic use an Electronic Health Record (EHR) software system? ☐ Yes ☐ No

If yes, which software vendor do you use? _____

If yes, what software version are you using? _____

CareOregon partners with BetterDoctor for quarterly provider directory validation. Contracted offices will receive an email, a fax or a mailed letter with a key to be entered into their proprietary portal for provider demographic validation. CareOregon wants to ensure our provider directory is current and accurate for our providers and members. Contracted provider support in this quarterly validation is required.

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Provider 1 Information

○ Add (effective date) _____ ○ Remove (effective date) _____

Last name: _____ First name: _____ MI: _____ Title: _____

DOB: _____ SSN (no dashes): _____ Individual NPI (type 1): _____ ☐ Male ☐ Female

Taxonomy code: _____ Oregon Medicaid ID: _____ Professional Lic#: _____

Primary directory specialty: _____ Secondary directory specialty: _____

Languages spoken other than English: _____

Accepting new patients? ☐ Yes ☐ No

At which locations does this provider take patient appointments?: ○ Location 1 ○ Location 2 ○ Location 3

Provider 2 Information

○ Add (effective date) _____ ○ Remove (effective date) _____

Last name: _____ First name: _____ MI: _____ Title: _____

DOB: _____ SSN (no dashes): _____ Individual NPI (type 1): _____ ☐ Male ☐ Female

Taxonomy code: _____ Oregon Medicaid ID: _____ Professional Lic#: _____

Primary directory specialty: _____ Secondary directory specialty: _____

Languages spoken other than English: _____

Accepting new patients? ☐ Yes ☐ No

At which locations does this provider take patient appointments?: ○ Location 1 ○ Location 2 ○ Location 3

Accessibility Requirements

Exam room:	☐ Yes ☐ No	Restroom:	☐ Yes ☐ No
Exterior building access:	☐ Yes ☐ No	Telecommunicate device:	☐ Yes ☐ No
Interior building access:	☐ Yes ☐ No	Waiting/reception access:	☐ Yes ☐ No
Parking:	☐ Yes ☐ No	Wheelchair weight scale:	☐ Yes ☐ No

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