OHA Managed care plan facility/clinic/provider group application through EOCCO

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

Section 1 Facility/clinic information ☐ Enrollment ☐ Reenrollment

Business name associated with IRS FEIN		Doing Business As (DBA) name		
Street address (A post office box is not a valid service location. Must enter a physical street address)		City	State	ZIP code
Mailing address (if different)		City	State	ZIP code
NPI	License number	License state	License effective date	License expiration date
FEIN (Tax Identification Number)[1]			County	
Taxonomy	Phone number	Organization type		

1. A copy of your W9 is required to submit with application

Section 2 Required information and additional information

- This is not a credentialing application. This is for registration with Oregon Medicaid. EOCCO will submit this application to OHA.
- This application does not contract as a network facility with EOCCO.
- **All fields are required for registration.** Any incomplete information will cause more time for validation to be able submit your application. Once we submit your application to the state, it can take approximately 30 days to approve, sometimes longer. When your application is approved, we can query any claims that denied for DMAP registration within the approved enrollment period and send them to be reprocessed.
- We are unable to submit this application without a completed OHA 3974 form.
- Information filled out needs to be legible. Unreadable information will cause delay in processing or cause your application to be withdrawn by OHA.
- If the ordering, prescribing, rendering or attending provider NPI on the claim is not registered on the date of service, your claim will be denied/stay denied for DMAP registration. Please fill out the "OHA Managed Care Provider Application Through EOCCO" form for the applicable provider on the date of service.
- Please include a copy of current year facility license and any previous year licenses as appropriate for dates of service that need to be covered for this enrollment request.
- Out-of-state facilities, further than 75 miles from the Oregon border, are enrolled for a six month period. If you are out-of-state and have a claim older than six months, please let us know all the dates of service needed for further enrollment extension.

  Dates: _____
- Copies of NPPES screens or other certifications are not required.
- Any claims attached will be used for determining requested enrollment period only. Claims should be submitted to claims processing address at PO Box 40384, Portland, OR 97240. The normal rule for timely filing is 120 days.
- In-state FQHC/RHC providers must contact the state directly to inquire about wraparound payments. FQHC/RHC enrollments processed through EOCCO are for encounter purposes only and are not eligible for wraparound (supplemental) payment.
- Any changes to ownership information (OHA 3974 form) must be reported to EOCCO in writing within 30 days.

Ready to submit? Mail, email or fax this form to EOCCO:
Mail: EOCCO Medicaid Services, 601 S.W. Second Ave., Portland, OR 97204
Email: ProviderDMAPApps@modahealth.com **Fax:** 503-265-4790

Questions? Contact EOCCO Customer Service toll-free at 888-788-9821. (TTY users, please dial 711.)

eocco.com

Clear Form

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

Purpose

Federal law requires fiscal agents, managed care entities (MCEs), and other Oregon Medicaid providers, including applicants and certain bidders seeking to provide Oregon Medicaid services, to disclose all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3.

Instructions

For these disclosures, the Oregon Health Authority (OHA) requires fiscal agents, MCEs, and other providers to complete this form entirely.

Submit tax identification numbers (TINs) for all individuals or entities reported using this form. Submit a Social Security number (SSN) for all individuals, and Employer Identification number (EIN) for all entities.

OHA requires SSNs in order to conduct the provider screenings required by 42 CFR § 455 Subpart E. See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice *(page 1 of the Information and Instructions at the end of this form)* to learn more about this requirement.

For questions about filling out this form, see the Information and Instructions (after page 5 of this form). Form will not be accepted if missing information such as TIN or DOB. Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, termination of its agreement or contract.

Please check each box that explains the reason for disclosure:

☐ New enrollment ☐ Reactivated enrollment ☐ Revalidation

☐ Change in ownership ☐ Change in managing employees

Contact name:
Contact phone:
Contact email:

Section I. Disclosing entity information

Legal name of provider *(individual, agency, facility or group)*:	
Doing Business As (DBA):	
TIN *(SSN for individual, EIN for entity)*:	**Service address:**
National Provider Identifier (NPI):	

Section II. Disclosure information

In this section, please report the following information:

Owner (5% or more):
List the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. For individuals, include DOB and SSN; for corporations, include TIN.

Subcontractor:
List all subcontractors who are related to the disclosing entity owners as a spouse, parent, child or sibling, where the disclosing entity has a 5% or more interest in the subcontractor.

Managing employee:
List the name, address, DOB and SSN of any managing employee of the disclosing entity.

Other interest:
List the name of any other disclosing entity or fiscal agent or managed care entity in which the owner of the disclosing entity has an ownership or control interest; or of any other individual or entity with other interest. Other interest in the provider can be:

- The owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity;
- An officer or director of the entity, if the entity is organized as a corporation; or
- Partner in the entity, if the entity is organized as a partnership.

Sanctions, exclusions or convictions:
Indicate whether the individual or entity reported on this form has experienced any of the following:

- **Sanction or exclusion** from participation in Medicare or any state health care programs;
- **Conviction** for a criminal offense or assessed civil penalties related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs, or as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act; **or**
- Transfer of their ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following any of these events.

Provider NPI #:

Disclosure # 1	
Person type. *Who is this disclosure for? Check one:*	
☐ Individual	☐ Corporation
Disclosure type. *Check all that apply:*	
☐ Owner (5% or more)	☐ Subcontractor
☐ Managing employee	☐ Other interest
Name	**Address** *(If corporate, list primary business address and PO Box if applicable)*
TIN *(SSN for individual, EIN for corporation)*	
Date of birth	

Sanctions, exclusions or convictions (42 CFR §455.100)

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? *Must select Yes or No. If Yes, check all that apply:* ☐ Yes ☐ No

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

Relationships

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

Name	**Relationship**

Other ownership or control interest

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

Provider NPI #:

Additional Disclosures (make copies as needed)	
Person type. *Who is this disclosure for? Check one:*	
☐ Individual	☐ Corporation
Disclosure type. *Check all that apply:*	
☐ Owner (5% or more)	☐ Subcontractor
☐ Managing employee	☐ Other interest
Name	**Address** *(If corporate, list primary business address and PO Box if applicable)*
TIN *(SSN for individual, EIN for corporation)*	
Date of birth	

Sanctions, exclusions or convictions (42 CFR §455.100)

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? **Must select Yes or No. If Yes, check all that apply:* ☐ Yes ☐ No

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

Relationships

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

Name	**Relationship**

Other ownership or control interest

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

Provider NPI #:

Section III. Business transactions: Only complete at the request of CMS or OHA

During the last 12-month period, has this entity had business transactions totaling more than $25,000 with a subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

During the last five years, has this entity had significant business transactions with any wholly owned supplier or subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the supplier or subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

Section IV. Disclosing entity's attestation, signature, and date

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. I understand that by knowingly providing false information on this form or in connection with any claim for payment from the State of Oregon, which may include federal funds, I may be liable for a false claim under the Oregon False Claims Act (ORS 180.750 to 180.785) and the federal False Claims Act (31 USC 3279 to 3733). I agree to inform OHA or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Name of authorized representative

Title

Signature

Date