Provider Contract Information

Oregon/Washington

PacificSource

The information provided on this form will be used to set up your provider, group, or facility records, as well as your contract and provider directory listing.

Solo practitioner
(one individual billing under the tax ID)

Name _____

Specialty _____

Language fluency _____

Individual NPI _____

Medicare ID _____

Medicaid ID _____

Practitioner's patient/client capacity _____

CAQH number _____

Group or facility (for more than one individual NPI billing under the tax ID or a provider billing with a Type II Organization NPI)

Name _____

Group NPI _____

Group Medicare ID _____

Group Medicaid ID _____

Please complete the Group or Facility Roster and return it to your PacificSource Contract Representative.

Group's total patient/client capacity _____

Billing with ☐ SSN ☐ EIN Tax ID number (from IRS W-9 form) _____ Tax ID effective date _____

Email of signature authority (person authorized to sign the participation agreement if offered) _____

Line of business requested (select all that apply)

- ☐ Commercial/coordinated care networks (PacificSource Health Plans)
- ☐ Medicare (PacificSource Community Health Plans)
- ☐ Medicaid (PacificSource Community Solutions). Providers are required to enroll with Medicaid in order to apply. See our Medicaid Provider Enrollment FAQ.

Please note: Not all networks are available to all providers. Your representative will determine your contracted networks.

Practice location information (for patient visits and directory listing)

☐ Check if this practice offers only telehealth/virtual care, not in-person care.

Practice name (as it should appear in the directory) _____

Address _____

City _____ State _____ Zip code _____ County _____

Location effective date _____ ☐ Adding location ☐ Changing location

Contact name _____ Contact email _____

Contact title _____ Practice phone _____ Practice fax _____

Do you require a separate fee for PacificSource members to access care with your providers? ☐ Yes ☐ No

Billing information (as listed on CMS 1500 field 33 or UB-04 box 2) ☐ Same as above

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip code _____ County _____

Location effective date _____ ☐ Adding location ☐ Changing location

Billing contact email _____

Billing contact phone _____ Billing contact fax _____

If you have a different contact for release of medical records, authorizations, etc., please list it in the Notes section.

Continued >

Additional information

Please provide additional information you would like us to consider to support you or your group joining PacificSource.

How many PacificSource members are under your care currently?

☐ None ☐ 1-5 members ☐ 6-10 members ☐ 11+ members

Form guidance

Specialty: If you are unsure what specialty to list, please see our Provider Manual.

Patient/client capacity: The maximum number of patients in a provider's member panel.

Credentialing: Our Provider Manual offers detailed information about our credentialing requirements. We also have a dedicated Credentialing team that can assist with your questions.

Notes

Form completed by _____ Role/title _____

Email _____ Phone _____ Date completed _____

Return this form to:

Oregon: ORContracting@PacificSource.com | **Washington:** WAContracting@PacificSource.com