Provider Contract Interest Form

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. PacificSource will review submissions based on network needs. Incomplete submissions will be returned or denied.

Specialty: If you are unsure what specialty to list, please see our Provider Manual at PacSrc.co/provider-manual.

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

Provider information
(one individual billing under the tax ID)

Name _____

Specialty _____

Provider type _____

Language fluency _____

Individual NPI _____

Medicare ID _____

Medicaid ID _____

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.

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) _____

Practice information

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

Address _____

City _____ State _____ Zip code _____ County _____

Location effective date _____

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 practice information**

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip code _____ County _____

Location effective date _____

Billing contact email _____

Billing contact phone _____ Billing contact fax _____

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Line of business information

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 at PacSrc.co/medicaid-provider-enrollment-guide. Following the initial review, additional panel application(s) and supporting documents will be required for further evaluation.

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

Care information

Service location? ☐ In-person only ☐ Telehealth only* ☐ Hybrid (in-person and telehealth)*

*Telehealth-only providers and hybrid (in-person and telehealth) providers are required to have and submit a Care Coordination Policy and Procedure as outlined within OAR 410-120-1990.

☐ I have attached my Telehealth Care Coordination Policy and Procedure.

Population information

What ages do you treat? Please check all that apply.

☐ Children 0–5 ☐ Children 6–12 ☐ Adolescents 13–17 ☐ Adults 18–64 ☐ Adults 65+

Patient/client capacity: Please indicate the maximum number of patients your member panel or group can serve _____

How many PacificSource members are under your care currently?

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

In the next six months, how many additional PacificSource members can your practice serve? _____

Please describe the populations you specialize in treating and for which you have additional training, proficiency, and certification.

Additional information

Please explain why you think that you or your group should join PacificSource.

Form completed by _____ Role/title _____

Email _____ Phone _____ Date completed _____

Return this form to:
Oregon: ORContracting@PacificSource.com
Washington: WAContracting@PacificSource.com