Oregon Organization Medicaid ID Application

PacificSource Community Solutions

1. Required forms

Facility, ambulance, DME, pharmacy, lab, etc.

- ☐ Completed PacificSource Oregon Medicaid ID application
- ☐ Completed OHA Provider Disclosure Statement form
- ☐ W9 federal tax form
- ☐ Copy of associated claim
- ☐ Healthcare License for your organization, issued by the State Health & Human Services Department, or equivalent state entity, or CMS/Medicare Certification

Group of professionals

- ☐ Completed PacificSource Oregon Medicaid ID application
- ☐ Completed OHA Provider Disclosure Statement form
- ☐ W9 federal tax form
- ☐ Copy of associated claim

2. Organizational information

Business name[1,2] _____ Provider type[3] _____

Federal employer ID no.[1] _____

NPI no.[2] _____ Taxonomy code[2] _____

Effective date (may be backdated to cover a previous date of service, up to one year) _____

Contact name (individual completing form) _____ Phone _____

Email address _____

[1] Entries must match what is on your W-9.
[2] Entries must match your registration with the National Plan & Provider Enumeration System: NPIRegistry.CMS.HHS.gov.
[3] DHS/OHA provider types: PacSrc.co/OHP

Is the provider organization owned or operated by a state, county, city, or other local governmental agency or instrumentality? ☐ Yes or ☐ No

3. Ownership disclosure (See 42 CFR 455.104 and 455.105 for full requirements)

☐ **For-profit** corporations, partnerships, LLCs, or PCs: List the following information for entities having direct or indirect ownership or controlling interest in the provider entity. List name, title, birth date, and Social Security number for individuals; list name, title, and Federal Employer Identification Number for an organization.

Name	Title	Birth date	SSN/FEIN

☐ **Not-for-profit:** Please include IRS 501(c) Determination letter.

Continued >

4. Location

Service location (physical address) _____

City _____ State _____ ZIP+4 _____

County _____ Phone _____

Mailing address (if different) _____

City _____ State _____ ZIP+4 _____

Please send all documents to 3108ORMedicaidProviderEnrollment@PacificSource.com or fax to **541-225-3643.**

Accessibility help: For assistance reading this document, please call us at **800-431-4135,** TTY: 711. We accept all relay calls.

OREGON HEALTH AUTHORITY

Oregon Medicaid

(Oregon Health Plan)

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

All pages of this form must be returned even if pages are blank. This form supersedes any previous form received for this enrolled / enrolling provider.

Is the disclosing entity organized as a corporation?
If yes, complete Section II, Question 2 and 3.

Please check the box that explains the reason for disclosure:

☐ New enrollment ☐ Re-enrollment ☐ Revalidation
☐ Change in ownership ☐ Change in managing employee
☐ Removal of owner or managing employee, **see page 20**
☐ Removal of director or officer if organized as a corporation, **see page 20**

Effective date: _____

Organization Information (disclosing entity)

Organization legal name:

_____

Doing Business As (DBA) name (if applicable):

_____

Federal Employer Identification Number (EIN) (## - #######): _____

National Provider Identifier (NPI): _____

Existing Medicaid Provider ID (MCD) (if known): _____

Business address (not mailing)

Street: _____

City: _____ State: _____ Zip: _____

Business type (check one)

- ☐ Corporation
- ☐ Limited partnership
- ☐ Tribally owned
- ☐ Government-owned
- ☐ Not-for-profit
- ☐ Limited Liability Corporation (LLC)
- ☐ Partnership
- ☐ Limited Liability Partnership (LLP)
- ☐ Professional corporation
- ☐ Other: _____

Purpose

Federal law requires a State Medicaid Agency (SMA) to complete Federal database checks on newly enrolling, enrolled, and revalidating providers. This includes any person (individual or organization) with an ownership or control interest or who is a managing employee of the provider (disclosing entity). See 42 CFR § 455.436

Disclosure of Social Security Number (SSN) is **required** pursuant to 41 USC 405(c)(2)(C)(i) to establish identification, 42 CFR 455.104 and 455.436 for exclusion verification and 26 CFR 301.6109-1 for the purpose of reporting tax information. OHA may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the name, Social Security Number (SSN) or Federal Employer Identification Number (FEIN) provided on this application. See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice to learn more about this requirement.

Agent / authorized signer information. (see Glossary for definition)

Agent name: _____ Agent email: _____

Agent phone number: _____ Agent fax number: _____

If the contact person for this request is different than the Agent listed above, list contact person below.

Contact name: _____ Contact email: _____

Contact phone number: _____ Contact fax number: _____

Section I: Identification of all owners

Section I, Question 1

List all individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more. Refer to glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest.

Individuals: List the name, primary business address, date of birth (DOB) and Social Security Number (SSN) for each person having a 5% or greater Ownership Interest in the Entity.

Entities: List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box address of each organization, corporation, or entity having 5% or greater Ownership Interest. Use Section IV to list the other business locations.

Note: If more space is needed attach a list with the required fields labeled, "Section 1, Question 1".

☐ Check this box if you attached a list.

☐ Check if there are no owners.

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN/TIN: ____________________

Section I, Question 2

List all individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of less than 5%. Refer to glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest.

Individuals: List the name, primary business address, date of birth (DOB) and Social Security Number (SSN) for each person having less than 5% Ownership Interest in the Entity.

Entities: List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box address of each organization, corporation, or entity having 5% or less Ownership Interest. Use Section IV to list the other business locations.

Note: If more space is needed attach a list with the required fields labeled, "Section 1, Question 2".

☐ Check this box if you attached a list.

☐ Check if there are no owners.

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Name of owner: ____

Street: ____

City: ____________________ State: ____________________ ZIP: ______________

Date of birth: ____________________ SSN/TIN: ____________________

Section II: Identification of all individuals and entities with a controlling interest

Section II, Question 1

Managing employee(s): Refer to glossary for definition.

List each individual who is a managing employee of the disclosed entity. Information to be disclosed must include name, date of birth (DOB), primary business address and Social Security Number (SSN). If no managing employee(s) is listed, form will be returned as incomplete.

Note: If more space is needed attach a list with the required fields labeled, "Section 2, Question 1".

☐ Check this box if you attached a list.

Name of managing employee: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of managing employee: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of managing employee: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of managing employee: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of managing employee: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of managing employee: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Section II, Question 2

Officers: Refer to glossary for definition.

This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

☐ Check this box if disclosing entity does not have any Officers.

List each individual who is an officer of the disclosing entity. Information to be disclosed must include name, date of birth (DOB), primary business address and Social Security Number (SSN)

Note: If more space is needed attach a list with the required fields labeled, "Section 2, Question 2".

☐ Check this box if you attached a list.

Name of officer: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of officer: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of officer: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of officer: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of officer: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Name of officer: ______________________________

Street: ______________________________

City: ______________ State: ______________ ZIP: ______________

Date of birth: ______________ SSN: ______________

Section II, Question 3

Directors: Refer to glossary for definition.

This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

☐ Check this box if disclosing entity does not have any Directors.

List each individual who is a director of the disclosing entity. Information to be disclosed must include name, date of birth (DOB), address and Social Security Number (SSN).

Note: If more space is needed attach a list with the required fields labeled, "Section 2, Question 3".

☐ Check this box if you attached a list.

Name of director: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of director: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of director: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of director: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of director: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Name of director: ____________________

Street: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Date of birth: ____________________ SSN: ____________________

Section II, Question 4

Controlling interest: Refer to glossary for definition.

This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

List the name, address, date of birth (DOB) and Social Security Number (SSN) for each person who has a Controlling Interest in the disclosing entity. List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box Address of each organization, corporation, entity having a Controlling Interest.

Note: If more space is needed attach a list with the required fields labeled, "Section 2, Question 4".

☐ Check this box if you attached a list.

Name of individual or organization: _____

Title: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of individual or organization: _____

Title: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of individual or organization: _____

Title: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of individual or organization: _____

Title: _____

Street: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN/TIN: _____

Name of individual or organization: ____________________

Title: ____________________

Street: ____________________

City: ____________ State: ____________ ZIP: ________

Date of birth: ____________ SSN/TIN: ____________

Name of individual or organization: ____________________

Title: ____________________

Street: ____________________

City: ____________ State: ____________ ZIP: ________

Date of birth: ____________ SSN/TIN: ____________

Name of individual or organization: ____________________

Title: ____________________

Street: ____________________

City: ____________ State: ____________ ZIP: ________

Date of birth: ____________ SSN/TIN: ____________

Name of individual or organization: ____________________

Title: ____________________

Street: ____________________

City: ____________ State: ____________ ZIP: ________

Date of birth: ____________ SSN/TIN: ____________

Name of individual or organization: ____________________

Title: ____________________

Street: ____________________

City: ____________ State: ____________ ZIP: ________

Date of birth: ____________ SSN/TIN: ____________

Name of individual or organization: ____________________

Title: ____________________

Street: ____________________

City: ____________ State: ____________ ZIP: ________

Date of birth: ____________ SSN/TIN: ____________

Section III: Ownership and controlling interest in other disclosing entities

Section III, Question 1

Complete this question if the individuals or organizations identified in Section I as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity**? Refer to glossary for definition.

List the name and SSN or TIN of the Other Disclosing Entity in which the Owner identified in Section I also has an Ownership or Controlling Interest.

Note: If more space is needed attach a list with the required fields labeled, "Section 3, Question 1".

☐ Check this box if you attached a list.

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Name of owner listed in Section I: ____________________

Name of other disclosing entity: ____________________

Other disclosing entity's SSN (individual) or TIN (entity): ____________________

Section IV: Ownership and controlling interest in subcontractors

Section IV, Question 1

If the disclosing entity has a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor**, list those below. Refer to glossary for definition.

If an individual or organization with an Ownership or Controlling Interest in any Subcontractor in which the disclosing entity also has Direct or Indirect Ownership Interest of 5% or more, list those below.

Note: If more space is needed attach a list with the required fields labeled, "Section 4, Question 1".

☐ Check this box if you attached a list.

Legal Name of Subcontractor:

_____

Subcontract TIN/SSN: _____

Name of Other Individual/Organization with Ownership or Controlling Interest:

_____

Other Individual/Organization's Complete Address (Street/City/State/Zip)

Street: _____

City: _____ State: _____ Zip: _____

Other Organization's TIN: _____ Other Individual's SSN: _____

Other Individual's DOB: _____ % Interest in Subcontractor: _____

Legal Name of Subcontractor:

_____

Subcontract TIN/SSN: _____

Name of Other Individual/Organization with Ownership or Controlling Interest:

_____

Other Individual/Organization's Complete Address (Street/City/State/Zip)

Street: _____

City: _____ State: _____ Zip: _____

Other Organization's TIN: _____ Other Individual's SSN: _____

Other Individual's DOB: _____ % Interest in Subcontractor: _____

Section V: Family relationships

Section V, Question 1

If any of the individuals identified in Sections I, II, III or IV, are related to each other (e.g., spouse, sibling, parent, child), list the individuals and relationship to each other.

Note: If more space is needed attach a list with the required fields labeled, "Section 5, Question 1".

☐ Check this box if you attached a list.

Name of individual #1	Name of individual #2	Relationship

Section VI: Criminal convictions, sanction, exclusions, debarment and terminations

Section VI, Question 1

If the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity ever had an administrative sanction, and/or been assessed a monetary sanction, and/or been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CCHIP or Title XX program since the inception of those programs, list those individuals and the required information below.

If the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity current under investigation by any program under Medicaid, Medicare, CCHIP or Title XX program since the inception of those programs, or the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity is currently being investigated, and/or has ever received a Credible Allegation of Fraud (CAF), a Civil Monetary Penalty (CMP), or has been sanctioned, excluded, debarred or terminated from Medicaid, Medicare, CCHIP or Title XX program, list those individuals and the required information below.

Note: Provide a copy of all related documentation pertaining to any sanction, exclusion, debarment, and/or conviction. If more space is needed attach a list with the required fields labeled "Section VI, Question 1".

Do you have additional documentation to attach? ☐ Yes ☐ No

Name: _____

DOB: _____ SSN (individual) or TIN (entity): _____

Complete address (Street/City/State/Zip)

Street: _____

City: _____ State: _____ Zip: _____

Reason for sanction, exclusion or debarment: _____

Date(s) of sanctions, exclusions or debarments: _____

Date of reinstatement (enter N/A if not reinstated): _____

List all States where currently excluded: _____

Agency involved: _____ Email for agency: _____

Phone number for agency: _____

Complete address of agency (Street/City/State/Zip)

Street: _____

City: _____ State: _____ Zip: _____

Name: _____

DOB: _____ SSN (individual) or TIN (entity): _____

Complete address (Street/City/State/Zip)

Street: _____

City: _____ State: _____ Zip: _____

Reason for sanction, exclusion or debarment: _____

Date(s) of sanctions, exclusions or debarments: _____

Date of reinstatement (enter N/A if not reinstated): _____

List all States where currently excluded: _____

Agency involved: _____ Email for agency: _____

Phone number for agency: _____

Complete address of agency (Street/City/State/Zip)

Street: _____

City: _____ State: _____ Zip: _____

Section VII: Removal of owner(s) or managing employee(s)

If additional space is needed to list the name(s) of previous owners or managing employees who need to be removed from the enrollment record, please enclose a separate page listing the name(s), DOB, SSN or TIN.

If removing owner(s), complete section I, if adding new owner(s).

Name of owner	SSN (individual) TIN (entity)	DOB (individual)

Complete the corresponding section(s) above if adding individuals to replace those removed.

Name of managing employee	SSN (individual)	DOB (individual)

Name of director or officer	SSN (individual)	DOB (individual)

Section VIII: Business transaction information

Section VII is not required at the time of supplying this form but may be required upon request of CMS or the State Medicaid Agency (SMA). By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the SMA.

Section VII, Question 1

Business Transactions – Subcontractors

List the information for Subcontractors with whom the disclosing entity has had business transactions totaling more than $25,000 during the previous 12-month period ending on the date of the request.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractors Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN (individual) or TIN (entity), and Subcontractor Owner's Address

Section VIII, Question 2

Significant Business Transactions – Wholly Owned Suppliers

List the information of any Wholly Owned Supplier with whom the disclosing entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VIII, Question 3

Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom the disclosing entity has had any Significant Business Transactions exceeding the lesser or $25,000 or 5% of operating expensed during any one fiscal year in the past 5-year period.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractors Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN (individual) or TIN (entity), and Subcontractor Owner's Address

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 1807.750 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.

Print name of provider agent / authorized signer	Title
Signature of provider agent / authorized signer	Date

Glossary – many of these definitions have been sourced from 42 CFR § 455.101.

Agent: means any person who has been delegated the authority to obligate or act on behalf of a provider. This individual also acts as an authorized signer for the entity.

Direct Ownership Interest: An individual or entity that possesses equity in the capital, the stock, or the profits of the disclosing entity. Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported (42 CFR §455.102).

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Indirect Ownership Interest: An individual or entity that has an ownership interest in an entity that has a direct or indirect ownership interest in the disclosing entity.

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported (42 CFR §455.102).

Managing Employee: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Officers and directors: All officers and directors must be disclosed if the disclosing entity is organized as a corporation. See question on page 1. This includes board members, board of directors, volunteers, and if a non-profit corporation has "trustees" instead of officers or directors, these trustees must be disclosed. To clarify further on "director" this would not be the Finance Director unless the Finance Director is also on the Board of Directors. However, if the Finance Director meets the definition of a managing employee, then the Finance Director should be disclosed as a managing employee.

Other Disclosing Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare

(b) (title XV III);

(c) Any Medicare intermediary or carrier; and

Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Person with an ownership or control interest means a person or corporation that;

(a) Has an ownership interest totaling 5 percent of more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct or indirect ownership interests equal to 5 percent of more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant Business Transaction: means any business transaction or series of related that, during any one fiscal year, exceeds the lesser of $25,000 or five percent (5%) of a providers total operating expenses.

Subcontractor:

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

How to safely submit your form

This form has private information. If you send it by email, someone else may accidentally get it or try to steal it. To keep your information safe, send it in one of these ways:

- Use the ODHS/OHA Secure Email System (Proofpoint): https://apps.state.or.us/forms/served/me3702.pdf.
- Mail it to: (Ask program to provide a mailing address)
- Fax it to: (Ask program to provide a secure fax number)
- Bring it to a local office: https://www.oregon.gov/odhs/pages/office-finder.aspx.

Other formats and languages

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Provider Enrollment at provider.enrollment@odhsoha.oregon.gov or 1-800-336-6016 (voice). We accept all relay calls.

Oregon Medicaid

(Oregon Health Plan)

Provider Enrollment Agreement

The Oregon Health Authority (OHA) administers Oregon's medical assistance program for individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other federally funded medical programs, called the Oregon Health Plan (OHP). To comply with Federal law 42 CFR 455 Subpart E, OHA is required to enroll eligible providers into the Oregon Medicaid Program, pursuant to Oregon Administrative Rule 943-120 and 410-120, as a condition of delivering health services to OHP members.

All providers including non-payable (non-billing), payable (billing), individuals and organizations must fill out and sign this Agreement and all other required documents to receive an OHP provider number from OHA. An OHP provider number must be issued before a claim or encounter for delivered health services or goods is sent to OHA for payment.

The type of providers enrolled by OHA are defined in OAR 410-120-1260 and include billing agents, managed care entities (MCEs) and other providers who order, refer or prescribe services or goods.

Provider name	National Provider Identifier (NPI)

Scope of Agreement

This Provider Enrollment Agreement sets forth the rights, responsibilities, terms and conditions governing provider participation in the Oregon Medicaid program. Per OAR 410-120-1260(17), the provision of health care services or items to OHP clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

To be eligible for enrollment, a provider must:

A. Complete and submit an Enrollment Application
B. Agree to and sign this Provider Enrollment Agreement (Agreement)
C. Complete, sign and submit a Medicaid Provider Disclosure Statement (organizations and billing providers only)

D. Be an eligible provider and meet the conditions in (OAR) 410-120-1260 and any rules directly related to the provider's service category and OHA program in effect on the date of enrollment, and,
E. Meet all the applicable state and/or federal licensure or certification requirements to assure OHA provider meets minimum qualifications to perform services under this Agreement. This includes maintaining a professional license or certification in good standing and compliance with all program rules and rules related to providers service category.
F. Pass all mandatory screening and validation steps.
G. This Agreement becomes effective the date approved by OHA for date requested on initial application.
H. For revalidation and any other circumstances, this Agreement becomes effective the date signed by Provider.
I. Failure to comply with the terms of this Agreement or any applicable CFR or OAR may result in termination, sanction(s) or payment recovery, subject to Provider appeal rights, pursuant to OHA rules.

Governance

Oregon's Medicaid program is authorized and governed by:

- Title XIX of the Social Security Act
- Title XXI of the Social Security Act
- Chapter IV and V of Title 42 of the Code of Federal Regulations (CFR);
- Oregon Revised Statue (ORS) 414;

This Agreement is governed by federal law pertaining to the Medicaid program and the laws of Oregon that include: OAR Chapters 410, 943 and any OAR applicable to provider's service category, e.g. Mental Health.

OHA's administrative rules are posted and available at all times on OHA's website and Oregon's Secretary of State (SOS) website. Federal regulations are posted and available at all times on Electronic Code of Federal Regulations (eCFR) and Federal Register websites. It is the provider's responsibility to become familiar with and abide by these rules.

Assurances

As an OHP provider, hereafter known as "Provider," and as a condition of payment for goods or services under this Agreement, you agree to:

Comply with applicable laws

A. Comply fully with all federal, state and local laws, rules, regulations, and statements of OHA policy applicable to the care, services, equipment or supplies including but not limited to OAR 410-120-1380, 410-172, 410-173, and this Agreement. Failure to comply with the terms of this Agreement or OHA rules may result in sanction(s) and/or payment recovery, which may also result in termination pursuant to federal regulation, OHA rule, and any contract(s) between the Provider and OHA.

B. Provider shall at all times be qualified, professionally competent and actively licensed where required by law to perform work under this Agreement.
C. Provider is not in violation of any Oregon Tax Laws. For purposes of this PEA, “Oregon Tax Laws” means a state tax imposed by ORS 320.005 to 320.150 and 403.200 to 403.250 and ORS chapters 118, 314, 316, 317, 318, 321, and 323, and the elderly rental assistance program under ORS 310.630 to 310.706 and local taxes administered by the Department of Revenue under ORS 305.620.

Disclosure

Provider understands and agrees that:

A. The information in the enrollment form(s) and all supporting documentation is true, accurate and complete. Information disclosed by a Provider is subject to verification. OHA will use this information for administration of the Oregon Medicaid program.
B. Loss, suspension or restriction of licensure, or certification, may result in immediate disenrollment.
C. Any deliberate omission, misrepresentation or falsification of information in enrollment form(s) or in any communication supplying information to OHA may be prosecuted under state or federal law.
D. All providers that request to enroll or are already enrolled are subject to additional screening by OHA at any time. Additional screening includes, but is not limited to, pre and post enrollment site visits and fingerprint and criminal background check.
E. Provider is not excluded or otherwise prohibited from participating in Medicare or any state Medicaid or CHIP programs. Provider has not been convicted of a criminal offense related to Medicare, Medicaid, CHIP or any federal agency or program.
F. Provider is not listed on the non-procurement portion of the General Service Administration’s “List of Parties Excluded from Federal procurement or Non-procurement Programs” currently found at https://www.sam.gov/portal/public/SAM/. Provider will not use public funds to support, in whole or in part, the employment of individuals in any capacity having contact with Medicaid eligible individuals who have been convicted of a crime as identified under ORS 443.004(3), are on the Office of Inspector General (OIG) list of excluded individuals or entities, on the System Award Management (SAM) exclusion list, or the Data Exchange (DEX).

Services

Provider understands and agrees that:

A. The Provider agrees that all health care, services, equipment or supplies billed to Medicaid must be medically necessary, a covered service as defined in OAR Chapter 410, and provided in accordance with all applicable provisions of statutes, rules and federal regulations governing the reimbursement of services or items under OHP in effect on the date of service. Rules for OHP services are listed in OAR 410-120-1160 and defined in OAR Chapter 410 and Chapter 309. Provider further agrees to:
   a. Provide services within the parameters permitted by the Provider's license or certification and agrees to bill only for the services performed within the specialty or specialties designated in the Provider application on file OAR 410-120-1260. The services of goods must have been actually provided to the OHP member by the Provider prior to submitting a claim or encounter to OHA.
   b. Provide all services under this Agreement as an independent contractor. Provider is not an "officer," "employee" or "agent" of OHA, as the term is used in ORS 30.265.

B. Provider is responsible for verification of client OHP eligibility and benefit coverage and following applicable prior authorization requirements before rendering services as required in OHA Rules and described in OAR 410-120-1140.

Recordkeeping and access to records

Provider understands and agrees to:

A. Keep such records as are necessary to fully disclose the specific care, services, equipment or supplies provided to OHP members for which reimbursement is claimed, at the time it is provided, in compliance with the applicable OHA rules and federal regulations in effect on the date of service. Provider is responsible for the completeness, accuracy and secure storage of financial and clinical records and all other documentation of the specific care, services, equipment or supplies for which the provider has requested payment as required by OAR 410-120-1360, 410-172-0620, 410-173-0045, and any program specific rules in OAR Chapter 410 and Chapter 309.

B. Provide upon request by either OHA, the Program Integrity Audit Unit (PIAU), the Office of Payment Accuracy and Recovery (OPAR), the Oregon Secretary of State's Office, Federal Government, and the Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU), or any duly authorized representatives, immediate access to review and make copies of any and all records relied on by Provider in support of care, services, equipment or supplies billed to the Oregon medical assistance program. The term "immediate access" means access to records at the time the written request is presented to the Provider.

Communication

Provider understands and agrees that:

Any communication or notices from the Provider shall be given in writing via personal delivery, fax, email or regular mail, postage prepaid to OHA. Provider must notify OHA of any changes to Provider's information such as, address, name, licensure, within 30 days of the date of the change.

Confidentiality

Provider understands and agrees to:

Comply with the Health Insurance Portability and Accountability Act (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, and federal regulations at 45 CFR Parts 160 and 164, and as amended. The Provider specifically acknowledges their obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations. Provider agrees to comply with requirements for identifying, addressing and reporting an incident or breach, regardless of whether the incident or breach was accidental or otherwise.

Security

Provider understands and agrees that:

The Provider represents and warrants that the Provider will establish and maintain privacy and security standards and practices that respect and safeguard the privacy and security of all information related to OHA and the agency's employees, equipment, providers, systems and service recipients, regardless of media. Provider shall ensure the proper handling, storage and disposal of all information accessed, created, obtained, reproduced, or stored by the Provider and its authorized users using privacy and security standards that meet or exceed standards set by laws, rules, and regulations in (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, OAR Ch 943, the Oregon Consumer Identity Theft Protection Act, ORS 646A.600 through 646A.628, and Oregon's Statewide Information Security Standards, applicable to the information exchanged by the Provider and OHA or received by the Provider as a servicer of this Agreement. Provider shall ensure proper disposal of equipment and information assets when authorized use ends, consistent with Provider's record retention obligations and obligations regarding information assets under this Agreement.

Accurate billing

Provider understands and agrees that:

A. All claims or encounters submitted to OHA must be certified by signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the care, service, equipment or supplies claimed were actually provided, medically appropriate, documented at the time they were provided, documented using required diagnosis (ICD-10-CM) and procedure codes (HIPAA), and were provided in accordance with professionally recognized standards of health care, OAR 410-120-1280 through 1340 and this Agreement.

B. The Provider or its contracted agency, including billing providers, shall not submit or cause to be submitted:
    a. Any false claim for payment;
    b. Any claim altered in such a way as to result in a payment for service that has already been paid;
    c. Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exceptions described in OAR 410-120-1280. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to OHA. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code; or
    d. Any claim for furnishing specific care, items, or services that has not been provided.

C. The Provider is responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's responsibility for the claims or encounters submitted on Provider's behalf. OHA may recover any overpayment(s) that OHA made to Provider, by withholding future payment(s) or other processes as authorized by law or Agreement. If Provider fails to correct billing practices after written notice by OHA of non-compliance with state rules will be liable for up to triple the amount of identified overpayment(s).

Payment

Provider understands and agrees that:

A. Provider will accept OHA’s payment as complete remuneration the amount paid in accordance with the reimbursement rate for services covered under OHP, except where payment by the client is authorized in the OARs. Payment will only be made to the enrolled provider who actually performs the service or to the Provider's enrolled billing provider for covered services rendered to eligible clients, OAR 410-120-1340.

B. OHA has sufficient funds currently available and authorized to make payments under this Agreement within OHA's biennial budget. Provider further understands and agrees that payment for services performed after the current biennium is contingent on OHA receiving from the Oregon Legislature appropriations or other expenditure authority sufficient to allow OHA, in its reasonable administrative discretion, to continue to make payments.

C. Provider must not bill OHP members for any services unless authorized by Oregon Administrative Rule.

D. Any overpayment made to Provider by OHA may be recouped by OHA as authorized by law including, but not limited to withholding of future payment to Provider. Provider’s failure to perform the work specific in the Agreement or to meet the performance standards established in this Agreement, may result in consequences that include, but are not limited to reducing or withholding payment; requiring Provider to perform at Provider’s expense additional work necessary to meet performance standards; and pursuing any available remedies for default including termination of this Agreement.

E. Provider is not an officer, employee or agent of OHA and shall not be deemed for any purpose an employee of the State of Oregon. The Provider shall perform all work as an

independent contractor, as defined in ORS 670.600, and is responsible for determining the appropriate means and manner of performance. Provider is responsible for all federal and state taxes applicable to compensation paid to Provider under this Agreement and, unless Provider is subject to backup withholdings, OHA may withhold from such compensation any amounts to cover Provider's federal or state tax obligations. Provider has no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency would prohibit Provider's work under this Agreement. Provider certifies it is not currently employed by the federal government.

F. OHA and Provider are the only parties to this Agreement and are the only parties entitled to enforce its terms. The parties agree that Provider's performance under this Agreement is solely for the benefit of OHA to accomplish its statutory mission. Nothing in this Agreement gives or shall be construed to give or provide any benefit or right, whether directly or indirectly to third persons that are any greater than the rights and benefits enjoyed by the general public.
G. As a condition of payment, Provider must meet and maintain compliance with the Provider enrollment and payment rules OAR chapter 410, division 120; 42 CFR 455.400 through 455.470, as applicable; and 42 CFR 455.100 through 455.106.

Discrimination

Provider understands and agrees to:

A. Comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.
B. Not discriminate against minorities, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts.
C. Provide services to Medicaid-eligible individuals without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability (as defined under the Americans with Disabilities Act). Medicaid services must reasonably accommodate the cultural, language and other special needs of the member.

Compliance with applicable laws

Provider understands and agrees that:

A. Provider shall comply and require all subcontractors to comply with federal, state and local laws and regulations, executive orders and ordinances applicable to items and services under this Agreement, including but not limited to OAR 407-120-0325, as they are amended from time to time. Without limiting the generality of the prior sentence, the Provider expressly agrees to comply and require all subcontractors to comply with all of the laws, regulations and executive orders listed under OAR 410-120-1380 to the extent they are applicable to the items and services provided under this Agreement.

B. Provider agrees that if any term or provision of this Agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected and the right and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.

Duration and termination of Agreement

Provider understands and agrees that:

A. This Agreement shall remain in effect for no more than five years from the effective date. OHA may terminate this Agreement at any time by written notice to the Provider by certified mail, return receipt requested, subject to any specific provider sanction requirements in OHA rules or Agreement(s) between OHA and the Provider.

B. OHA will terminate or suspend this Agreement if:
   a. The Provider or a person with 5 percent or greater direct or indirect ownership interest in the Provider, its agent or managing employee fails to submit timely, complete and accurate information, or cooperate with any screening requirements, unless OHA determines it is not in the best interests of the Medicaid program;
   b. Any person with a 5 percent or greater direct or indirect ownership interest in the Provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or title XXI program in the last 10 years, unless OHA determines it is not in the best interests of the Medicaid program;
   c. The Provider is terminated under title XVIII of the Social Security Act or under the Medicaid program or Children's Health Insurance Plan (CHIP) program of any state;
   d. The Provider or any person with a 5 percent or greater, direct or indirect, ownership interest in the Provider fails to submit sets of fingerprints in a form and manner to be determined by OHA within 30 days of a Centers for Medicare and Medicaid Services (CMS) or a OHA request, unless OHA determines it is not in the best interests of the Medicaid program;
   e. The Provider fails to permit access to Provider locations for any site visits under 42 CFR 455.432, unless OHA determines it is not in the best interests of the Medicaid program;
   f. CMS or OHA determines that the Provider has falsified any information provided on the application or if CMS or OHA cannot verify the identity of the Provider applicant.
   g. OHA fails to receive funding, appropriations, limitations or other expenditure authority at levels that OHA or the specific program determines to be sufficient to pay for the services or items covered under this Agreement;
   h. Federal or state laws, regulations or guidelines are modified, or interpreted by OHA in a manner that either providing the services or items under the Agreement is prohibited or OHA is prohibited from paying for such services or items from the planned funding source;
   i. OHA issues a final order revoking this Agreement based on a sanction under termination terms and conditions established in program-specific rules or policies, if required;

j. The Provider no longer holds a required license, certificate or other authority to qualify as a Provider. The termination will be effective on the date the license, certificate or other authority is no longer valid;
k. The Provider fails to meet one or more of the requirements governing participation as a OHA enrolled Provider. In addition to termination or suspension of the Agreement the Provider number may be immediately suspended in accordance with OAR 407-120-0360;
l. Provider commits any material breach or default of any covenant, warranty, or obligation under this Agreement, fails to perform the work under this Agreement or fails to pursue the work as to endanger Provider's performance under this Agreement in accordance with its terms;

C. Provider may terminate this Agreement at any time, subject to specific Provider termination requirements in OHA rules, OHA program-specific rules or federal regulations by submitting a written notice, in person, or by certified mail listing a specific termination effective date. The request must be in writing and signed by the provider. The notice shall specify the OHA-assigned provider number to be terminated and the effective date of termination. Termination of this Agreement does not relieve the Provider of any obligations for covered services or items provided for the dates of services during which the Agreement was in effect.

Insurance requirements

Required insurance: During the term of this Agreement, Provider shall possess any and all insurance required within the program rules based on Provider type and any business requirements set forth by the Department of Consumer and Business Services at Providers cost and expense. The insurance may include, but is not limited to, general liability, professional liability, malpractice, workers compensation, employer's liability, excess/umbrella insurance, tail coverage, etc. Provider must retain any and all certificate(s) and proof of insurance, notice of change or cancellation, insurance reviews, state acceptance or other actions on the providers insurance.

Upon request, Provider will provide to OHA not more than thirty (30) days of any change, reduction, suspension, cancellation or termination of Provider's insurance coverage required by this section.

OHA may exempt Provider from these requirements for any reason, including but not limited to the inability of Provider to procure such insurance.

Indemnification

Provider shall defend (subject to ORS Chapter 180), save, hold harmless, and indemnify the State of Oregon and OHA and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever, including attorney fees, resulting from, arising out of, or relating to the activities or omissions of Provider or its officers, employees, subcontractors, or agents under this agreement.

Provider: I have read the foregoing Agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for other sanctions as provided by statute, administrative rule, or this Agreement.

Provider or authorized signature

I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Oregon Medicaid Program and/or prosecution for Medicaid fraud. I certify that I have read and understand the federal and state laws rules and regulations as cited in this Agreement. I agree to abide by the Oregon Medicaid Program terms and conditions listed in this document and aforementioned regulations.

Print name of Provider or authorized official	Title of authorized official *(if applicable)*
Signature of Provider or authorized official	Date

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Provider Enrollment at provider.enrollment@odhsoha.oregon.gov or 1-800-336-6016 (voice). We accept all relay calls.