Oregon Provider Medicaid ID Application

PacificSource Community Solutions

Please return this completed form by email to MedicaidProvNet@PacificSource.com or fax to **541-225-3643**. All fields are required if applicable.

Request Information

Contact Name (individual completing form) _____

Effective Date[1] _____ Phone _____

Provider Information

Name _____

Birth Date _____ Social Security No. _____

Specialty _____

License No. _____ NPI No.[2] _____

License Effective Date _____ Expiration Date _____

Licensing Board _____ State of Issue _____

Primary Taxonomy Code[2] _____ Description _____

Secondary Taxonomy Code[2] _____ Description _____

Other Taxonomy Code[3] _____ Description _____

[1] If more than six months from the date the state receives the request, your DMAP liaision will contact you for additional information.
[2] Entries must match your registration with the National Plan & Provider Enumeration System. See provider type by visiting the link below.

For DHS/OHA Provider Types, go to Oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx.

Service Location

Street Address _____

City _____ State _____ ZIP+4 _____

County _____ Phone _____

Mailing Address (if different) _____

City _____ State _____ ZIP+4 _____