

Provider Capacity Form

Applicable to Medicaid-contracted primary care providers



1. Individual Providers

Check here if you are a primary care provider

Check here to accept auto assignment (PCPs only)

Provider Name _____ Specialty _____

Provider NPI _____ Tax ID _____ Individual Provider Capacity _____

2. Provider Group

Check here if your group is a primary care office

Check here to accept auto assignment (PCP groups only)

Provider Group Name _____ Specialty _____

Specialty _____

Group NPI _____ Tax ID _____ Provider Group Capacity _____

Note: Unless otherwise specified, group capacity will be evenly dispersed among all providers.

3. Provider Locations (if multiple, please identify)

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Please send this form to: ORProviderService@PacificSource.com

Questions: Please contact your Provider Service Representative:
ORProviderService@PacificSource.com or **541-246-1457**