Oregon and Washington Provider Information Request

PacificSource HEALTH PLANS

The information on this form is required for claims processing and directory listings.

Please use additional forms for additional practice locations or practitioners/organizations.

1. What change(s) are you making with this form?

☐ Add Existing Provider to Group
☐ Update Information
☐ Add Provider to Hospital-based Location[1]
☐ Termination (Date): ____ / ____ / ____ Reason: _____

Effective date for this change at your organization: ____ / ____ / ____

Effective date will match the date of credentialing approval, provided a contract is in effect on that date. Additionally, Oregon Medicaid providers must obtain a MAP ID and be approved by Medicaid.

This provider is: ☐ Contracted directly with PacificSource ☐ Contracted with an independent provider association (IPA) or Accountable Care Organization (ACO)

Providers on Delegated Credentialing Agreements must notify the entity that Credentials their providers and/or Facilities of any changes submitted on this form.

2. Provider Information (name as shown on CMS 1500 field 31 or UB box 1)

☐ Individual Practitioner ☐ Organizational Provider ☐ PCP ☐ Specialist

Name _____

NPI _____ Degree _____ Birth Date: ____ / ____ / ____ ☐ Male ☐ Female

License No. _____ DEA No. _____

3. Practice Location Information (for patient visits and directory listing)

Practice Name (as it should appear in directories) _____

Address _____

City _____ State _____ ZIP _____ County _____

Practitioner Specialty (as practicing at this location) _____

Search the NPI directory for specialties at ***npiregistry.cms.hhs.gov***

List this location in directories? *Some provider types, including hospital-based, won't be listed.* ☐ Yes ☐ No

Location NPI _____ Tax ID No. (attach IRS W9) _____

Contact Name _____

Contact Email _____

Practice Phone _____ Practice Fax _____

[1]Hospital-based Provider: Providers who practice exclusively in an in-patient setting. A credentialing application is not required.

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4. Billing Information (as billed on CMS 1500 field 31 or UB box 2)

☐ Same as Above

Billing Name (as it appears on claims) _____

Address _____

City _____ State _____ ZIP _____ County _____

Billing Contact Name _____

Billing Contact Email _____

Billing Contact Phone _____ Billing Contact Fax _____

5. Other Changes to Provider Directory

_____

_____

_____

_____

6. Summary of Changes/Notes

_____

_____

_____

_____

Form Completed By _____

Email _____ Phone _____

_____

Return to: Mail: PO Box 7068, Springfield, OR 97477
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Email: provnetsupport@pacificsource.com