Trillium Community Health Plan Health Net

Credentialing Alliance

OREGON PRACTITIONER DATA FORM

Directions for completing the Oregon CAQH/Oregon Practitioner Credentialing Application (OPCA)

SUBMIT THIS FORM and if not enrolled in CAQH submit all required documents:
TCH_PROVIDEROPERATIONS@CENTENE.COM
HNOR_PROVIDEROPERATIONS@HEALTHNET.COM

1. **CAQH Registration is recommended** (http:/www.caqh.org—for assistance please contact the CAQH HELP DESK at 1-888-599-1771)
2. **Your CAQH application and attestation MUST** be up to date and each health plan you are requesting participation in is authorized to access your data
3. **Ensure you provide an ACCURATE CAQH number or your application may be delayed or rejected**
4. **PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THE APPLICATION IN ITS ENTIRETY**
   a. Additional office locations-please indicate any additional locations on the attached Supplemental Sheet
   b. Another Supplemental Sheet is included if necessary, to identify additional Practitioners in Call Group They must be contracted with the plan
   c. That same Supplemental Sheet has space if necessary, to include all hospital and ambulatory surgery centers where you have privileges
5. **Please complete the OPCA, if not enrolled in CAQH** (pages 5-18)
6. **The following attachments are required to be submitted with the OPCA so your request may be processed timely**

PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST
This form includes Personally Identifiable information (PHI) such as practitioner name, date of birth and SSN and should be sent in a secure manner.

Post the following items (as applicable) to CAQH/Email-Check box to indicate items posted:

☐ OPCA (if not enrolled in CAQH)
☐ Oregon Licensure
☐ DEA (if applicable)
☐ Cultural Competence Training
☐ Certificate of Professional Liability Insurance
☐ Hospital Admit Plan (in the event of an emergency while providing services to a member)

Provider/Group Name (Required)	Organizational NPI#	Tax ID #:
Practice Location Name (DBA) if applicable:		
Practitioner's Name and Degree: (Last) (First) (M.I.) (Degree)	**CAQH #**	☐ Male ☐ Female ☐ Non-Binary/non-conforming
Practitioner's Effective Date w/Practice		

Group Type:	Practitioner Type:
☐ FQHC/RHC ☐ Ancillary ☐ Group Practice ☐ Clinic	☐ PCP ☐ Specialist

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Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	Is provider a Medicare participating provider? ☐ YES ☐ NO		Hospital Based ☐ YES ☐ NO
SSN:	Individual NPI#	DOB:	Medicare #:
License #: State: Exp Date:	DEA # State: Exp Date:		Medicaid (DMAP) I.D. #
Primary Practicing Specialty Taxonomy: Secondary Practicing Specialty Taxonomy:		If PCP, member capacity (number of members):	
Accepting New Patients: ☐ YES ☐ NO	Patient Age Range:	Patient Gender: ☐ Male ☐ Female ☐ Any ☐ Transgender ☐ Non-Binary/non-conforming	
Do you provide services to individuals with special needs/chronic conditions (*check all that apply*) ☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None		Physician Assistant Supervising Physician Name	
Do you provide services/accommodations to individuals who have difficulty communicating or cooperating (i.e.,) those with autism or intellectual disabilities? ☐ YES ☐ NO		Do you provide services to individuals with mobility limitations (i.e., wheelchair bound? ☐ YES ☐ NO	
Do you treat any of the following diagnoses (*check all that apply*): ☐ Anxiety ☐ AHDS ☐ EPSDT ☐ Depression ☐ HIV ☐ Substance Abuse ☐ None			
Do you participate in VFC (Vaccines for Children)? ☐ YES ☐ NO	VFC PIN CODE:	Do you E-Prescribe? ☐ YES ☐ NO	
Names of Practitioners in Call Group (Must be contracted with plan) *Space for additional names at end of application*	Hospital & Ambulatory Surgery Center(s) where practitioner has privileges. *Space for addition names at end of application*		

Languages other than English spoken by PRACTITIONER:

Languages other than English spoken by OFFICE STAFF:

Race/Ethnicity: ☐ Black/African ☐ Hispanic/Latino/Spanish ☐ White/Caucasian ☐ Asia
☐ Native American/American Indian, Native Hawaiian/Pacific Islander ☐ Prefer not to disclose
☐ Other (*please add*)

BILLING SERVICE (if applicable)	Name:		Contact:	
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

PAY TO ADDRESS (all payments sent to this address)	Address:	City:		State:
	Phone:	Fax:		Zip Code:
PRIMARY ADDRESS (Physical location where services are performed) Supplemental sheet attached for additional addresses	Address:	City:	State:	Zip Code:
	Phone:	Fax:		County:
	Office Hours (Circle all that apply) M T W TH F S S		Time Open:	Time Closed:
	Special note *(i.e. closed for lunch, etc*)			
	List Practitioner in Directories at this address? ☐ YES ☐ NO			

OFFICE CONTACT/MAILING ADDRESS:	Name/Title:		Phone:	Fax:
	E-mail:		Office Website Address:	
	Address:	City:	State:	Zip Code:
CREDENTIALING CONTACT:	Name:		E-mail:	
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

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SUPPLEMENTAL FORM FOR ADDITIONAL ADDRESSES

PLEASE NOTE: A separate Disclosure of Ownership must be completed for each location unless the accommodations are the same as the Primary Address. If the accommodations are the same, indicate "ALL" on the form under Practice Location. **If accommodations do vary by location, as separate Assessment must be completed. Indicate appropriate address location on the form under Practice Location.**

ADDITIONAL ADDRESS (Physical location where services are performed) Supplemental sheet attached for additional addresses	Address:	City:	State:	Zip Code:
	Phone:	Fax:	County:	
	Office Hours (Circle all that apply) M T W TH F S S	Time Open:	Time Closed:	
	Special note (*i.e. closed for lunch, etc*)			
	List Practitioner in Directories at this address? ☐ YES ☐ NO			

ADDITIONAL ADDRESS (Physical location where services are performed) Supplemental sheet attached for additional addresses	Address:	City:	State:	Zip Code:
	Phone:	Fax:	County:	
	Office Hours (Circle all that apply) M T W TH F S S	Time Open:	Time Closed:	
	Special note (*i.e. closed for lunch, etc*)			
	List Practitioner in Directories at this address? ☐ YES ☐ NO			

ADDITIONAL ADDRESS (Physical location where services are performed) Supplemental sheet attached for additional addresses	Address:	City:	State:	Zip Code:
	Phone:	Fax:	County:	
	Office Hours (Circle all that apply) M T W TH F S S	Time Open:	Time Closed:	
	Special note (*i.e. closed for lunch, etc*)			
	List Practitioner in Directories at this address? ☐ YES ☐ NO			

ADDITIONAL ADDRESS (Physical location where services are performed) Supplemental sheet attached for additional addresses	Address:	City:	State:	Zip Code:
	Phone:	Fax:	County:	
	Office Hours (Circle all that apply) M T W TH F S S	Time Open:	Time Closed:	
	Special note (*i.e. closed for lunch, etc*)			
	List Practitioner in Directories at this address? ☐ YES ☐ NO			

SUPPLEMENTAL FORM FOR ADDITIONAL PRACTITIONERS IN CALL GROUP AND HOSPITAL/AMBULATORY SURGERY PRIVILEGES

PRACTITIONERS IN CALL GROUP (*MUST BE CONTRACTED WITH PLAN*)	**HOSPITALS AND AMBULATORY SURGERY CENTER(S) WHERE PRACTICTIONER HAS PRIVILEGES:**

Cultural Competency Continuing Education
Recordkeeping Form

Do Not Return This Form to the Oregon Medical Board, unless audited

ORS 676.850 (HB 2011) requires cultural competency continuing education as a condition of license renewal, every other time a license is renewed. Continuing education must be approved by the Oregon Health Authority or meet the skill requirements established by OHA. The form below may be used to document your completion of the requirement.

Name:	License #:
Course Name or Description of Educational Experience:	
Sponsor of Continuing Education (if applicable):	
Location:	
Date:	# CE Hours:

☐ Course approved by the Oregon Health Authority, list of OHA approved courses

☐ Course or experience meets the skills requirements established by the Oregon Health Authority

Continuing Education Format (select one)

- ☐ Course delivered either in person or electronically
- ☐ Experiential learning such as cultural or linguistic immersion
- ☐ Service learning
- ☐ Specially designed cultural experiences

Continuing Education Content (select all that apply)

Teach attitudes, knowledge and skills that enable a health care professional to care effectively for patients from diverse cultures, groups and communities.

- ☐ Applying linguistic skills to communicate effectively with patients from diverse cultures, groups and communities
- ☐ Using cultural information to establish therapeutic relationships
- ☐ Eliciting, understanding and applying cultural and ethnic data in the process of clinical care
- ☐ Other, please explain: _____

Signature _____ Date _____