EOCCO Provider Interest Form for In-Network Participation

Instructions: This form should be typed or completed legibly in blue or black ink. If you need additional space, please attach additional sheets, which reference the question(s) being answered.
Once completed, submit this document to credentialing@gobhi.org

Provider Identification			
Legal Business Name:		Doing Business As (DBA) (if applicable):	
Tax Identification Number:		Provider NPI Number:	
Telephone Number:		Email Address:	
Please list the address for the location(s) where the additional services are to be provided. Use additional pages if necessary.			
Organization Location			
Facility Name:	Street Address:		
City:	State:	ZIP Code:	County(s) Served:
☐ Participating Medicare provider?	Medicare Number:		
☐ Participating Oregon Medicaid provider?	Medicaid Number:		
Please list the types of services/procedure(s) and procedure code(s) that the provider would like to provide:			
Procedure(s)/Service(s):		Procedure Code(s):	
*Does the provider currently hold the appropriate certification(s) and/or license(s) required by state rule and/or federal regulation to provide the proposed service? ☐ Yes ☐ No			
**The provider must provide verification of all certifications and licenses required to provide the service upon application.*			
Please identify the physical accessibility of this office (ADA):	☐ Basic ☐ Limited ☐ None		
Office Hours of Operation:	Languages spoken by staff: Languages spoken by licensed practitioners:		
Certified language interpretation available at this site?	☐ Yes ☐ No		
Material available in alternate formats (audio, braille, large print, etc.)? ☐ Yes ☐ No			