



eoocco

EASTERN OREGON
COORDINATED CARE
ORGANIZATION

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 contracting@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):
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*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