HRSN Provider Training Module:

Enrolling as an HRSN Service Provider

2024

What we will cover today

In this training, we will go over the HRSN service provider enrollment process for Open Card/fee-for-service providers.

This training is for:

- Individuals and organizations **already enrolled** with Open Card.
- Individuals and organizations that are **new to working** with Open Card.

Existing Open Card providers

If you are already enrolled as a provider with OHP Open Card/fee-for-service (with a non-HRSN provider type):

- You must go through the enrollment process **again** to become an HRSN Service Provider.

If you are already an HRSN Service Provider and you want to add a specialty:

- For example, if you are an HRSN Outreach and Engagement provider and want to add Housing:
  - Send an email to Provider.Enrollment@odhsoha.oregon.gov
  - Write “HRSN” in the subject line.
  - Let Provider Enrollment know which specialty/service you’d like to add.

Existing Open Card providers

To view which specialty or specialties you are enrolled in, view the "Type and Specialty" screen in MMIS.

Type and Specialty

Provider Type 68 [Search] **License Number**

Type Description Health Related Social Needs

Primary	Provider Specialty	Specialty Description	Taxonomy	Effective Date	End Date
Yes	681	Health Related Social Needs - Outreach/Engagement	9999999999	01/01/1900	12/31/2299
No	682	Health Related Social Needs - Housing Services	9999999999	11/01/2024	12/31/2299
No	683	Health Related Social Needs - Nutrition Services	9999999999	01/01/2025	12/31/2299

Select row above to update -or- click Add button below.

Primary: Provider Specialty [Search]

Specialty Description

Taxonomy

Taxonomy Description

Effective Date

End Date

Healthcare Indicator Yes

Provider Contacts

Name	Title	Contact Type	Usage	Phone	Ext	Cell Phone	Effective Date

Starting the provider enrollment process

New Open Card providers

If you or your organization are new to working with Open Card and want to enroll as HRSN Service Providers, you'll need to:

1. Complete the required forms for your provider type
2. Submit the required forms using the MMIS Provider Portal

We will go over this process for the rest of the training.

Organization or individual?

1. **Before you enroll as a provider, determine if you are applying as an individual provider or an organization/group.**

- An **individual** provider is a person or sole proprietor who will directly bill Medicaid and uses an SSN as the Tax ID.

- An **organization/group** is an entity, corporation or other organization that bills OHP for services performed by their employed or contracted providers. Uses an EIN as the Tax ID.

Please note: Only the individuals and organizations that will be billing OHP or are going to be present on claims should enroll.

Completing required forms

Complete all required forms

Before starting the online provider enrollment process:

- Complete all required forms and save them to your computer.
- The online process does not replace the required forms.
- The online process is a tool to submit required forms.
- You will upload the forms at the end of the online enrollment process.

Make sure each completed form:

- Is a PDF, TIFF or TXT file.
- Is a file size of 10 MB or less and
- Has a file name that is 256 characters or less.

Which forms are required?

You will need to complete and upload the following forms at the end of the online provider enrollment process:

Organizations:

- ❑ Provider Enrollment Information form (OHP 3972)
- ❑ Provider Disclosure Statement form (OHP 3974)
- ❑ Provider Enrollment Agreement form (OHA 3975)

Individuals:

- ❑ Provider Enrollment Information form (OHP 3972)
- ❑ Provider Enrollment Agreement form (OHA 3975)

Provider Disclosure Statement (OHA 3974)

a. **Who needs to fill out a Provider Disclosure Statement form?**

  a. All enrolling organizations must fill out the Provider Disclosure Statement form.

  b. It is a **federal requirement** to list out the Date(s) of Birth and Social Security Number(s) of the individual(s) **who own 5% or more** of the organization and a managing employee.

  c. Please do not skip this step. Reference the definitions on page 7 of the 3974 form for more information.

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de3974.pdf

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Print | Save | Reset

Oregon Medicaid
(Oregon Health Plan)

Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

All pages of this form must be returned even if pages are blank. This form supersedes any previous form received for this enrolled / enrolling provider.

Please check the box that explains the reason for disclosure:

- ☐ New Enrollment
- ☐ Re-enrollment
- ☐ Revalidation
- ☐ Change in ownership
- ☐ Change in managing employee
- ☐ Removal of owner or managing employee ***see page 12***
- ☐ Removal of director or officer *if organized as a corporation* ***see page 12***

Organization Information (disclosing entity)

Organization legal name:	
Doing Business As (DBA) name *(if applicable)*:	Federal Employer Identification Number (EIN) (## - #######):
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:
Business address (not mailing) Street: City:	State: Zip:

Business type ***(check one)***

- ☐ Corporation
- ☐ Limited Partnership
- ☐ Tribally owned
- ☐ Government-owned
- ☐ Not-for-profit
- ☐ Limited Liability Corporation (LLC)
- ☐ Partnership
- ☐ Other: *(enter below)*
- ☐ Limited Liability Partnership (LLP)
- ☐ Professional Corporation

Is the disclosing entity organized as a corporation? ☐ Yes ☐ No
If yes, complete Section II, Question 2 and 3 are also required.

Provider Disclosure Statement 200-438416 OHA 3974 (Rev. 01/2024)
Page **1** of **15**

Provider Enrollment Agreement (OHA 3975)

a. Provider name:

a. Write the name of the enrolling individual or organization

b. National Provider Identifier (NPI)

a. While HRSN service providers are not required to provide an NPI, check with your claims department to see if it'd be helpful for you to get an NPI.

c. Signature

a. The signature page is required.

b. Send all pages sent to Provider Enrollment.

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3975.pdf

MEDICAID DIVISION
Provider Enrollment Unit

Oregon Health Authority

Print Save Reset

Oregon Medicaid
(Oregon Health Plan)

Provider Enrollment Agreement

The Oregon Health Authority (OHA) administers Oregon's medical assistance program for individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other federally funded medical programs, called the Oregon Health Plan (OHP). To comply with Federal law 42 CFR 455 Subpart E, OHA is required to enroll eligible providers into the Oregon Medicaid Program, pursuant to Oregon Administrative
services to OHP members.

All providers including non-payable
fill out and sign this Agreement and
from OHA. An OHP provider numb
services or goods is sent to OHA fo

The type of providers enrolled by O
managed care entities (MCEs) and

Provider name

Indemnification

Provider shall defend (subject to ORS Chapter 180), save, hold harmless, and indemnify the State of Oregon and OHA and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever, including attorney fees, resulting from, arising out of, or relating to the activities or omissions of Provider or its officers, employees, subcontractors, or agents under this agreement.

Provider: I have read the foregoing Agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for other sanctions as provided by statute, administrative rule, or this Agreement.

Provider or authorized signature

I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Oregon Medicaid Program and/or prosecution for Medicaid fraud. I certify that I have read and understand the federal and state laws rules and regulations as cited in this Agreement. I agree to abide by the Oregon Medicaid Program terms and conditions listed in this document and aforementioned regulations.

Print name of Provider or authorized official | Title of authorized official *(if applicable)*

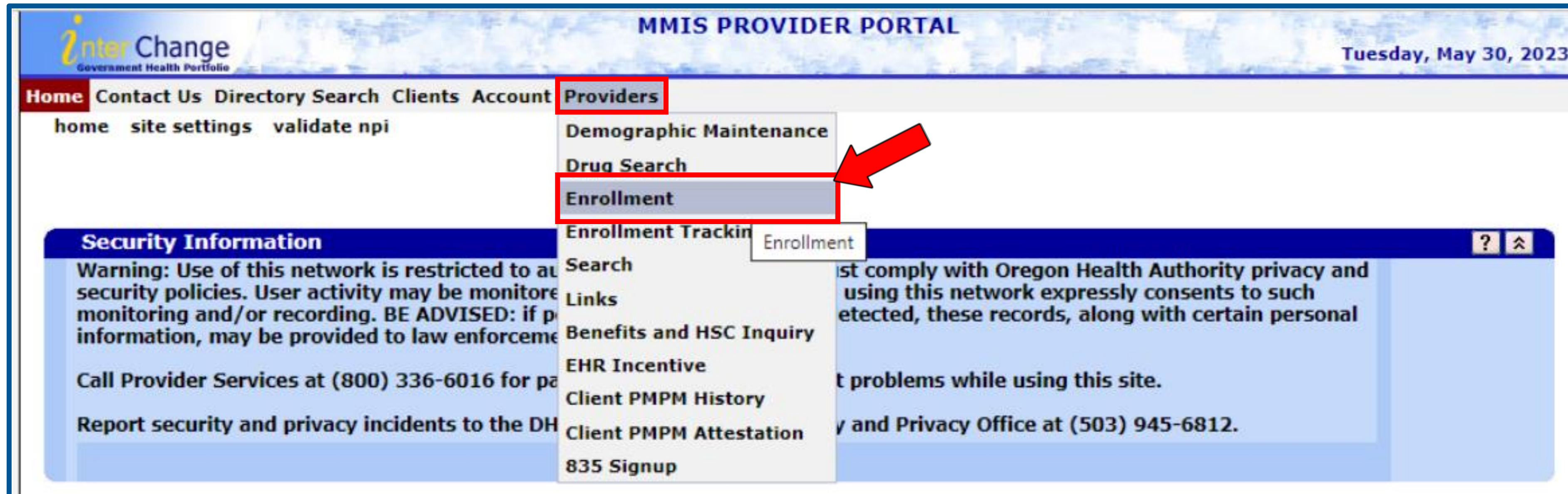
Signature of Provider or authorized official | Date

Submitting your forms through the MMIS Provider Portal

1. Open the provider enrollment portal

a. Find the portal by visiting: https://www.or-medicaid.gov/

Do not log into the portal.

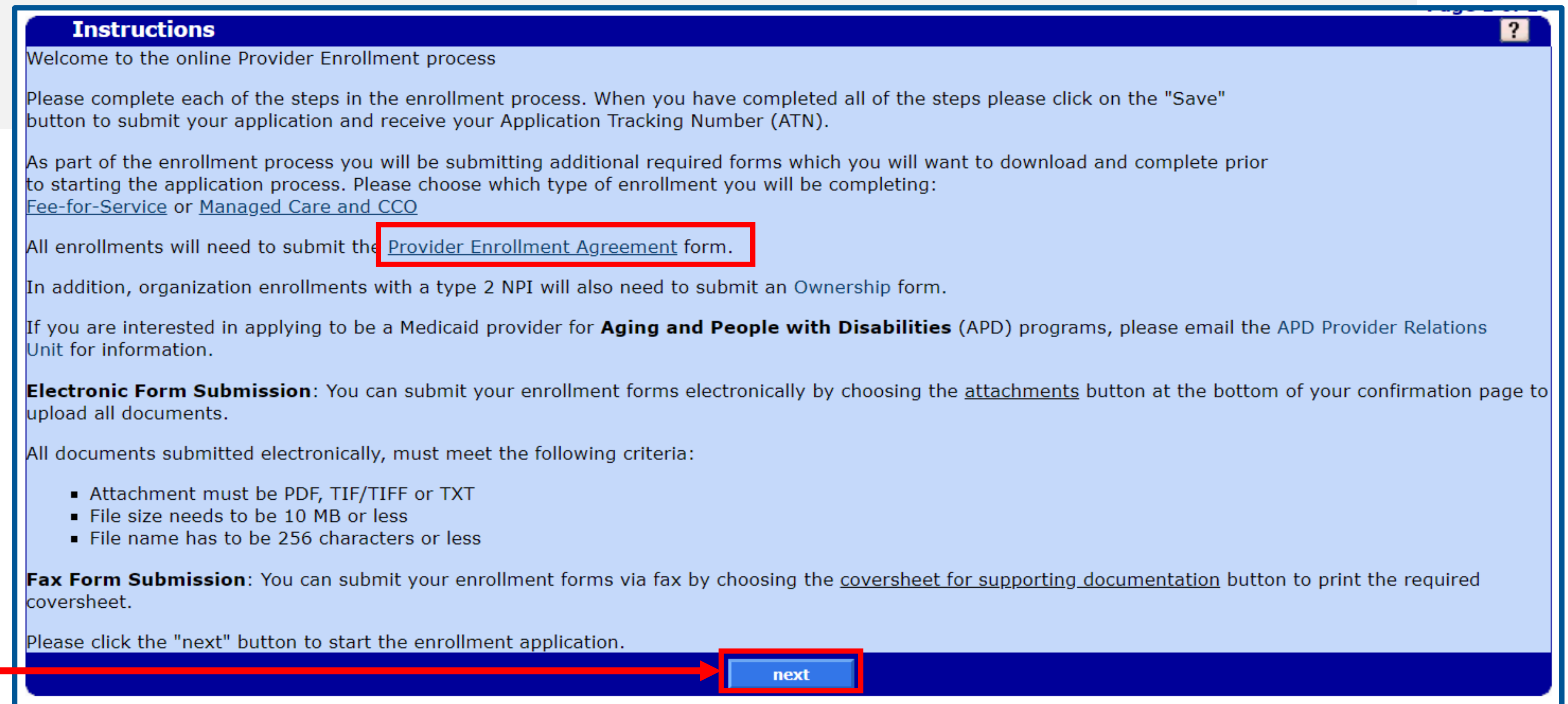


b. Open the step-by-step instructions for enrolling:
https://www.oregon.gov/oha/HSD/OHP/Tools/Provider-Enrollment-Guide.pdf

2. Instructions

a. **Ensure that you have completed the required enrollment forms** (mentioned in the previous slides).

b. **Click "Next"**

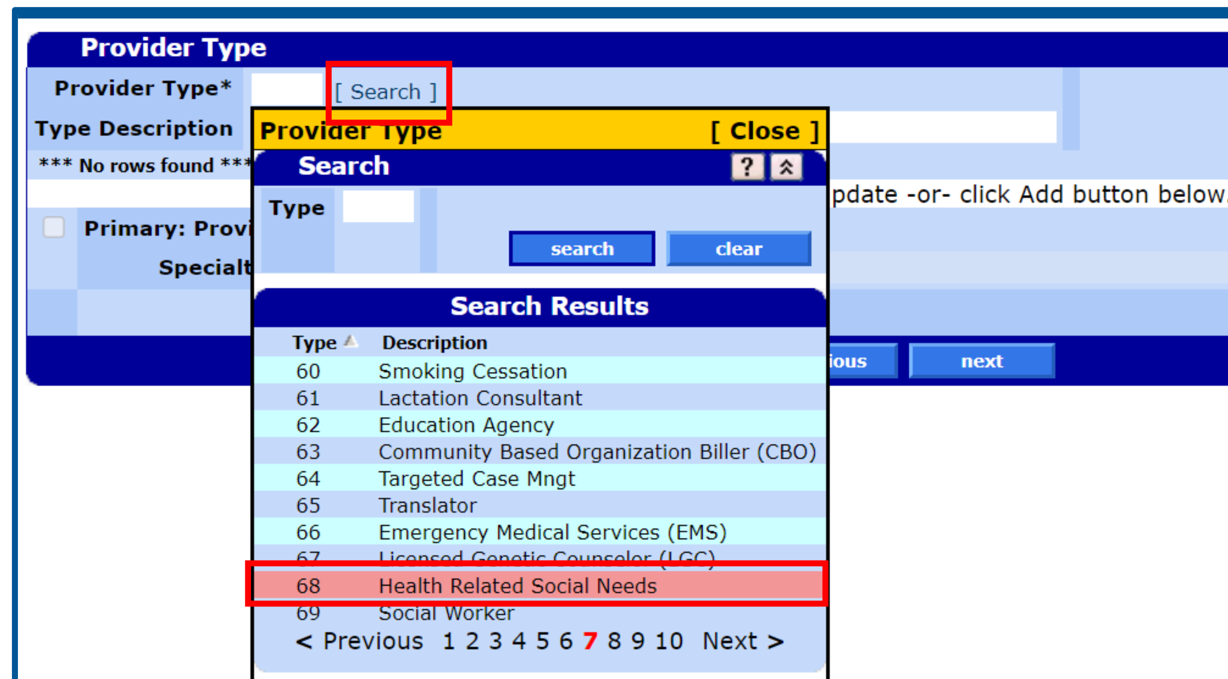


3. Provider type and specialty

To enter your Provider Type:

a. If you know the provider type number, you can enter it in the field.

b. If you don't know the number, click "**search**." You can click the "**Next**" button or the page numbers at the bottom of the search panel to find the provider type.



3. Provider type and specialty

Provider Types:

a. A list of enrollable types and specialties can be found on the Provider Enrollment webpage. https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx

b. **Health Related Social Needs (HRSN) providers** are **Type #68** on the list:

   a. 680: Health Related Social Needs – Climate Services

   b. 681: Health Related Social Needs – Outreach/Engagement

   c. 682: Health Related Social Needs – Housing Services*

   d. 683: Health Related Social Needs – Nutrition Services**

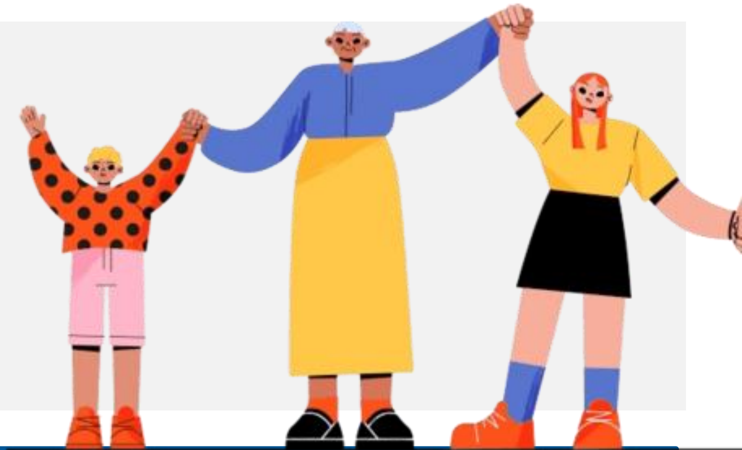
*HRSN housing providers may begin enrolling as of August 1, 2024; benefits launch in November 2024.
**HRSN nutrition providers may begin enrolling as of August 1, 2024; benefits launch in January 2025.

3. Provider type and specialty

To select Provider Specialty:

a. Click “**Add**” then “**Search**”

b. Find your **Provider Specialty** from the dropdown list



Provider Type* 68 [Search]

Type Description Health Related Social Needs

Primary Provider Specialty Specialty Description

A

Type data below for new record.

Primary: Provider Specialty* [Search]

Specialty Description

delete add

Primary: Provider Specialty [Close]

Search Results

Provider Specialty	Specialty Description	Provider Type
108	Encounter Only	68
680	Health Related Social Needs - Climate Services	68
681	Health Related Social Needs - Outreach/Engagement	68
682	Health Related Social Needs - Housing Services	68
683	Health Related Social Needs - Nutrition Services	68

3. Provider type and specialty

Check ✓ the box next to "Primary: Provider Specialty*":

a. Click "**Next**"

Provider Type

Provider Type*	68 [Search]
Type Description	Health Related Social Needs

	Primary	Provider Specialty	Specialty Description
A	Yes	680	Health Related Social Needs - Climate Services

Type data below for new record.

☑ Primary: Provider Specialty*	680 [Search]
Specialty Description	Health Related Social Needs - Climate Services

previous | next

4. Base information

Application Type*

a. Individuals and organizations enrolling as HRSN service providers should select "**HRSN-Health Rel**" from the dropdown list.

Base Information

Application Type* HRSN-Health Rel

Application NPI

License

License State

License Type

License Certification

License Certification End

UPIN

Ownership

Birthdate*

SSN*

Ambulatory Surg
Billing Provide
Chemical Depend
Dentist
Dialysis
Durable Medical
Encounter Only
Facility
Federally Quali
Home Health
Homecare Worker
Hospice
Hospital
HRSN-Health Rel
Independent Lab
Licensed Clinic
Limited Access

Name Type*

Name*

Address 1*

Address 2

City*

State*

Zip*

Phone*

Contact

Gender

4. Base information

Birthdate and SSN:

a. If you are applying as an **individual**, use the **individual's birthdate** and **SSN**.

b. If you are applying as an **organization,** use **01/01/1900** for the birthdate and nine zeros ("**000000000**") for the SSN.

License Certification

License Certification End

UPIN

Ownership No

Birthdate*

SSN*

previous

Why is SSN required?:

It is required to validate the provider against the exclusion databases.

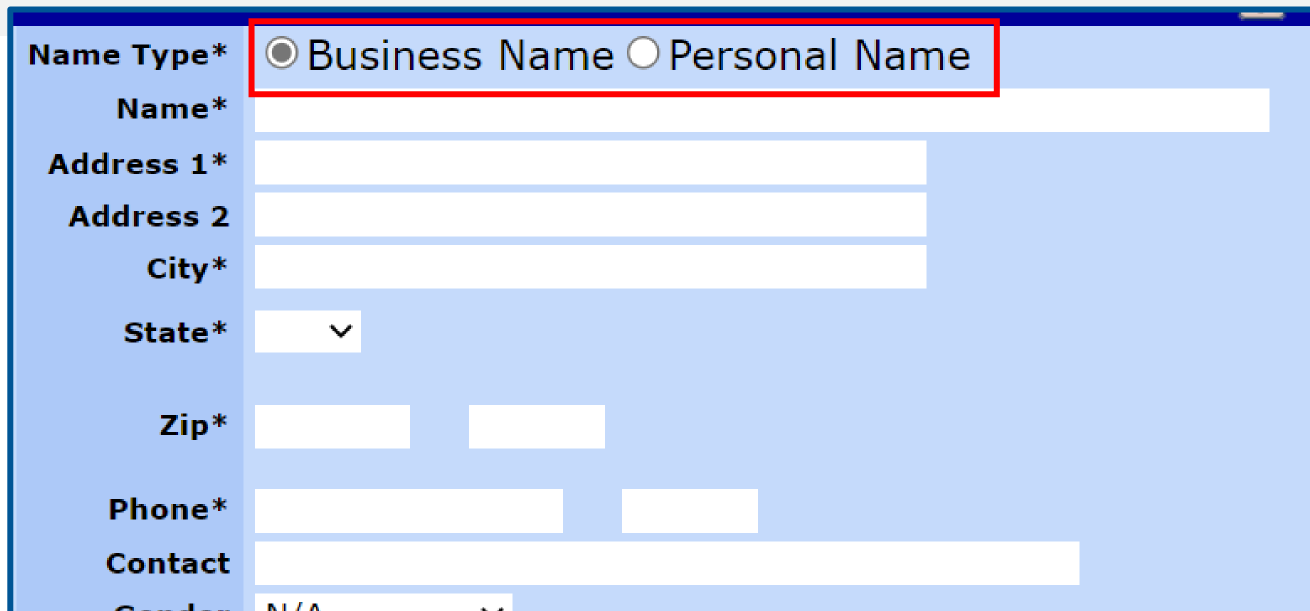
4. Base information

Name type:

a. If you are applying as an **individual**, select “**Personal Name**”.

b. If you are applying as an **organization,** select “**Business Name**”

After selecting the name type, fill out the rest of the information.



Received an error for address?

If you receive an error, you may change the address to:

500 Summer St NE, Salem, OR 97301

Provider Enrollment will then change the address when they process your application.

5. Service Location

County:

a. Use the dropdown boxes to choose your County".

Organization Code*:

a. **Organizations:** Use the dropdown box to choose your Organization Code.

b. **Individuals:** For non-payable individuals, select "**Individual**".

Service Location
County* 005 Clackamas
Organization Code*
Corporation
Estate/Trust
Government Owned
Group Practice
Individual
Limited Liability Corporation
Limited Liability Partnership
Limited Partnership
Not-for_profit
Other
Partnership
Professional Corporation
Public Service Org
Sole Proprietorship

6. Taxonomy

Not required

a. This information is not required. Click “**Next**” to skip.

Taxonomy

*** No rows found ***

Select row above to update -or- click Add button below.

Primary: Taxonomy [Search]

Taxonomy Description

previous next

7. Tax ID

Tax ID:

a. If you are applying as an **individual:**
    a. For IRS Tax Type, select: "**SSN**" and enter the applicant's SSN under IRS Tax ID
b. If you are applying as an **organization:**
    a. For IRS Tax Type, select: "**FEIN**" and enter the organization's Employer Identification Number (EIN) under IRS Tax ID.

Tax ID

IRS Tax Type*

IRS Tax ID*

FEIN
SSN

previous next

8. Address

Do not update this page.

a. This information is auto-populated from prior screens. Click “**Next**” to skip.

(Note: The screenshot below is an example address only.)

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Addresses

	Usage	Name	Address 1	City	State	Zip	Zip + 4	Phone	Ext	Handicap Access
A	Home Office	TEST	500 SUMMER ST NE	SALEM	OR	97301	1064	(503)979-6980		N
A	Mail to	TEST	500 SUMMER ST NE	SALEM	OR	97301	1064	(503)979-6980		N
A	Pay to	TEST	500 SUMMER ST NE	SALEM	OR	97301	1064	(503)979-6980		N
A	Service Location	TEST	500 SUMMER ST NE	SALEM	OR	97301	1064	(503)979-6980		N
A	Corporate Office	TEST	500 SUMMER ST NE	SALEM	OR	97301	1064	(503)979-6980		N
A	Medical Records	TEST	500 SUMMER ST NE	SALEM	OR	97301	1064	(503)979-6980		N

Select row above to update.

Name Type: Business Name / Personal Name

Name

Title

In Care Of

Usage

Country

Address 1

Address 2

International Address

City

State

Zip

E-Mail

Cell Phone

Phone

Fax

International Phone

International Fax

ADA Accessible? Yes

Language Format Indicator

Written

previous | next

9. Contacts

Add at least one contact

a. Click “**Add**” to type in information. A **name** and **email address** are required.

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Contacts

Name	Title	Contact Type	Usage	Phone	Ext	Cell Phone	Effective Date	End Date
TEST							07/29/2024	12/31/2299

Type data below for new record.

Name*

Title

Contact Type

Usage

Phone

Cell Phone

Fax

Email

Effective Date 07/29/2024

End Date 12/31/2299

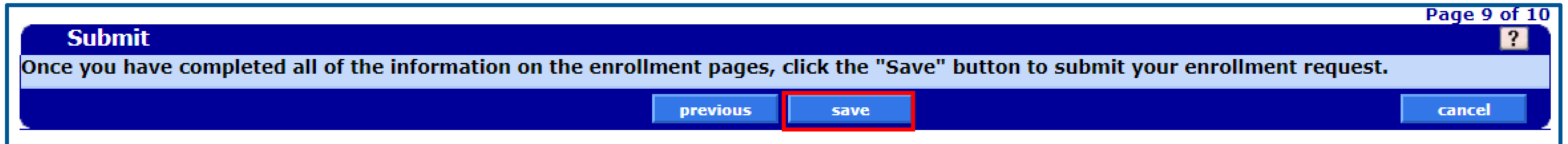
delete add

previous next

10. Submit

Submit application

a. Click “**Save**” to finalize your submission.
    a. **You will be able to upload documents on the next screen.**
b. Click “**Previous**” if you need to make any edits.



11. Completion

IMPORTANT

Attach documents on this screen. **Once you leave this screen, you can't return to it.**

Completing the application

a. This page has your **Application Tracking Number. Write the ATN down.**

b. Click "**Attachments**" to upload documents to your application.

The following messages were generated:

Message Description	Panel	Field	Row
Save was Successful.	Instructions		

Page10 of 10

Completion

The Enrollment Information has been submitted successfully and will be reviewed.

Please make sure to print this page for your records.

The Application Tracking Number (ATN) is : 6360105

As part of the enrollment process you will need to submit additional required forms which you have or need to download and complete to finish the application process. If you need to review the enrollment forms please choose which type of enrollment you have completed: Fee-for-Service or Managed Care and CCO

All enrollments will need to submit the Provider Enrollment Agreement form.

In addition, organization enrollments with a type 2 NPI will also need to submit an Ownership form.

Electronic Form Submission: You can submit your enrollment forms electronically by choosing the attachments button at the bottom of this page to upload all documents.

All documents submitted electronically, must meet the following criteria:

- **Attachment must be PDF, TIF/TIFF or TXT**
- **File size needs to be 10 MB or less**
- **File name has to be 256 characters or less**

Fax Form Submission: You can submit your enrollment forms via fax by choosing the coversheet for supporting documentation button to print the required coversheet. You can also reference Instructions for Submitting Supporting Documents for further details.

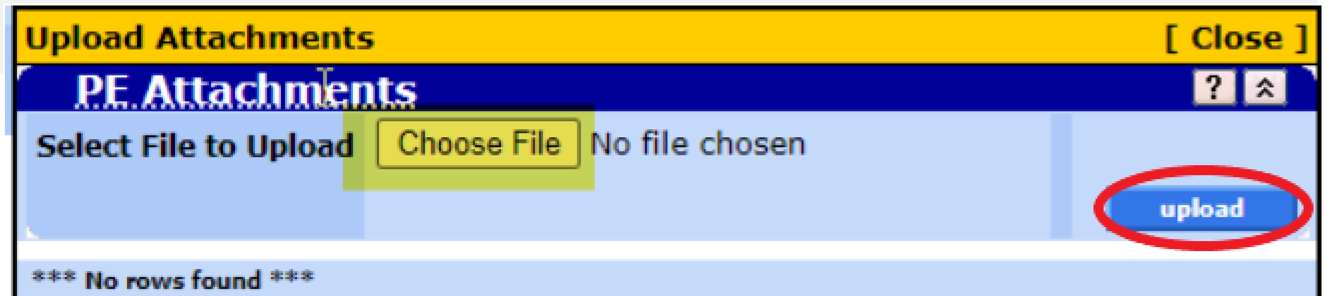
You can use the ATN to check the status of your enrollment application using the Application Tracking Tool

Attachments | Coversheet for supporting documentation

11a. Attachments

How to upload attachments

a. After clicking on “**Attachments**,” click “**Choose File**”, select your form, then click “**upload**.”



Please note:

- **This is the only time you will be able to add attachments to your application.** If you need to send more information later, you will need to submit the application again.
- You cannot use the **Provider Portal to view files attached to your application.** Please save the files you upload if you want to keep them for future reference.
- If you call to verify that the attachments have been received, note that it takes about **one hour** for the attachments to be viewable by OHA.

12. Notify OHA of your submission

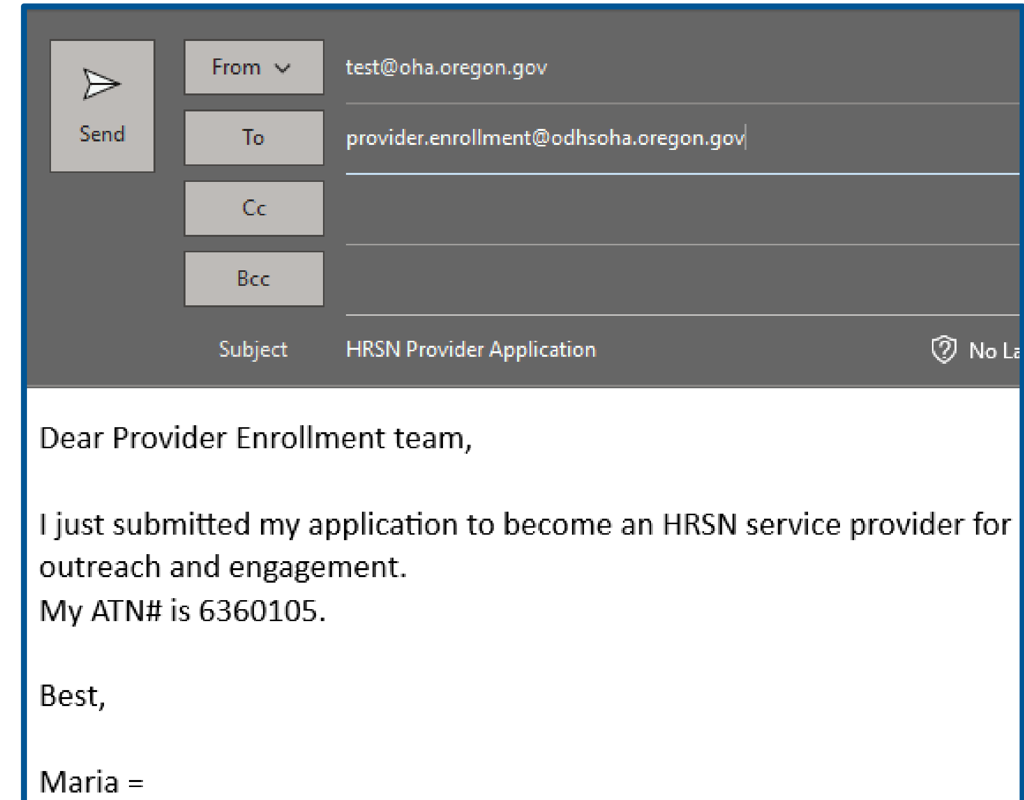
Once you've completed the application:

Email the Provider Enrollment Team at Provider.Enrollment@odhsoha.oregon.gov letting them know that you submitted an application to become an HRSN Service Provider.

a. In the subject line, write: “**HRSN**”

b. In the body of the email, write your **ATN#**.

HRSN applications are currently being expedited.



Next steps

After submission

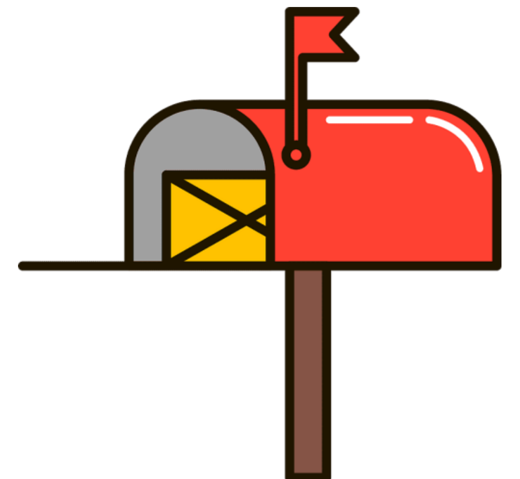
Congratulations! You've successfully submitted your application to enroll as an HRSN Service Provider.

- If we need more information, we will notify you by email or mail.
- If you cannot apply on the web page, you can fax your application to Provider Enrollment at 503-378-3074. Be sure to check the "Provider Enrollment" box on the EDMS Coversheet.

Check your mail

Once you are enrolled as a provider, you will receive two communications:

1. **Email:** A welcome letter will be emailed to you. This letter has your Medicaid Provider ID.
2. **Mail:** A PIN letter is system generated and will be mailed to you. You will need this PIN to access the Provider Web Portal to check OHP member eligibility.



Frequently Asked Questions

Frequently asked questions

- **How long does enrollment take after submitting an application?**
  - HRSN applications are currently being expedited. Please notify OHA of your application (see the previous “Notify OHA of your submission” slide.)
- **Can the enrollment be backdated, or can backdated claims be submitted?**
  - Enrollment applications may be backdated up to a year but not before the program effective date.
- **Do I need to complete the enrollment forms as well as the online application?**
  - Yes. The web portal is just an upload tool for providers to get their enrollment forms to OHA. This is to replace having forms being faxed.

Frequently asked questions

- **I submitted my application and forgot to add the attachments. How do I submit them?**
  - If you submitted an application without the attachments, the application will need to be completed again. Apply again and make sure to add the attachments.

Frequently asked questions: HRSN-specific

- **Is there a separate “easier” process for enrolling HRSN providers?**
  - No, the enrollment process is the same for HRSN providers.
- **Can organizations participate as an HRSN service provider if they are receiving funding from other federal sources/donations?**
  - The HRSN program is not intended to replace or duplicate services through other funding sources. Organizations must balance other state and federal funding they are receiving to ensure they are approaching service delivery appropriately.
- **How can an HRSN provider get access to MMIS to check member eligibility?**
  - If a provider completes the Medicaid Provider Enrollment process with OHA, they will gain access to MMIS to look up eligibility and member CCO enrollment information.

More support

Still have questions?

- **For enrollment questions:**
  - Call OHA's Provider Enrollment Team at 800-336-6016, option 6, or email Provider.Enrollment@odhsoha.oregon.gov.

- **For assistance with provider web portal setup and password unlock/reset requests:**
  - Call Provider Services at 800-336-6016, option 5 or email: TEAM.Provider-access@odhsoha.oregon.gov

More training: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Social-Needs-Provider-Training.aspx

Thank you!