Oregon
Tina Kotek, Governor

Department of Human Services
Office of Developmental Disabilities Services
500 Summber St NE E-09
Salem, OR 97301-1073
Voice: 503-399-9300
Fax 503-378-5756

To: RNs, LPNs and Agencies

Oregon Department of Human Services

As a Health Care Provider, providing services to children in the Medically Fragile Children's Unit (MFCU) or Children's Intensive In-Home Services (CIIS), you are a Medicaid health care provider and will be required to apply for an NPI and Taxonomy code. The NPI is a 10-digit, numeric identifier that does not expire or change and is administered by the Centers for Medicare & Medicaid Services (CMS).

Apply for your NPI at the National Plan and Provider Enumeration System (NPPES) website https://nppes.cms.hhs.gov/#/ . You may also call the NPI Enumerator at 1-800-465-3203 and request a paper NPI application form. You MUST have an NPI number in order to be paid by CIIS. Once you have received your NPI number please notify me at 971-388-9300 or CIIS.providers@odhsoha.oregon.gov .

If you have any questions please call me.

Sincerely,
Heather Ferris
CIIS

Oregon Medicaid

(Oregon Health Plan)

What is this request for? – *choose one*

See instructions on page 2 for required forms.

☐ New or re-enrollment

☐ Provider update – actively enrolled

☐ Revalidation - *check box **only** if request is for a provider who received notice to revalidate or has been instructed to complete by Provider Enrollment*

Definitions and enrollment information – *choose one*

☐ Payable Individual

Payable Individual – Individual provider who is enrolling to bill Oregon Medicaid directly (not through an organization) for services using their individual National Provider Identifier (NPI). This includes Sole Proprietors who intend to use their Social Security Number (SSN) or their Federal Employer Identification Number (FEIN) and associated name for payment / tax purposes.

☐ Organization

Organization – Groups, clinics, LLC, non-profit, etc., who is enrolling to bill Oregon Medicaid for services rendered by individual providers using the organizations National Provider Identifier (NPI).

Business type – check all that apply *(organizations only)*

Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Is the Provider owned or operated by a State, county, city or other local governmental agency or instrumentality? ☐ Yes ☐ No

☐ Corporation ☐ Limited Partnership ☐ Other: *(enter below)*

☐ Government-owned ☐ Not-for-profit

☐ Limited Liability Corporation (LLC) ☐ Partnership

☐ Limited Liability Partnership (LLP) ☐ Professional Corporation

General information

All Providers as defined in OAR 410-120-1260(3)(a) are required to enroll with Oregon Medicaid. OHA may deactivate providers who do not have any claim activity in an 18-month period. OHA recommends that you enroll if you have rendered services to an Oregon Medicaid Member in the last 12-months or plan to see a member within the next 30 days.

Provider Enrollment reserves the right to make necessary changes to the information submitted such as provider type, specialty, and taxonomy. This action is necessary to correctly enroll the provider.

Disclosure information

Disclosure of Social Security Number is required pursuant to 41 USC 405(c)(2)(C)(i) to establish identification, 42 CFR 455.104 and 455.436 for exclusion verification and 26 CFR 301.6109-1 for the purpose of reporting tax information. OHA may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the name, Social Security Number (SSN) or Federal Employer Identification Number (FEIN) provided on this application.

Instructions for submitting forms

The OHA 3972 is to enroll, re-enroll, update, or revalidate providers seeking direct reimbursement from the Oregon Health Authority (OHA). Failure to complete required sections will delay processing.

- Fax **all** pages of form(s), starting with the EDMS Coversheet to 503-378-3074.
  Or
- Submit completed form(s) online. See ***Provider Enrollment Guide*** on Provider Enrollment webpage.
- OHA 3972 (Provider Enrollment Information)
- OHA 3974 (Provider Disclosure Statement – organizations only) – ***not required for general updates disclosed on the OHA 3972.***
- OHA 3975 (Provider Enrollment Agreement) – ***not required for updates.***
- Provider Enrollment Attachment – To find out which attachment your provider requires, visit the OHP Provider Enrollment page. ***Not required for updates or revalidations***
- Other – include any additional documentation listed in the required documents section of the OHP Provider Enrollment web page or as stated within this form.

Outdated forms are not accepted. Visit the OHP Provider Enrollment Website:
https://www.oregon.gov/OHA/HSD/OHP/Pages/Provider-Enroll.aspx

You may call or email Provider Enrollment 48 hours after faxing your application to verify receipt. 800-336-6016, option 6. Enrollment forms are not accepted via email.
Provider.Enrollment@odhsoha.oregon.gov

If this request is for a provider who is providing telehealth services fee-for-service or open card OHP members, the provider is required by OAR 410-120-1990 to hold an unencumbered Oregon license. If the provider is out-of-state, the provider is also required by OAR 410-120-1260 to be licensed in the state where the provider is located. The service location on this application should reflect where the provider is physically located, and the license should reflect the Oregon license.

Is this request for a telehealth provider? ☐ Yes ☐ No

Payable individual provider information (required – only complete if application selection on page 1 is for payable individual)

Last name:	First name:	Middle Initial:
Social Security Number (SSN):	Date of birth (DOB):	
Doing Business As (DBA) name *(if applicable)*:		
Federal Employer Identification Number (FEIN) *if applicable*:		
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:	

Organization provider information *(required – only complete if application selection on page 1 is for organization)*

Legal name:	
Doing Business As (DBA) name *(if applicable)*:	
Federal Employer Identification Number (FEIN):	
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:

Type, Specialty, and Taxonomy information (required)

See type and specialty list on Provider Enrollment webpage.

Provider Type Code:
Specialty Description:
Primary Taxonomy Number:
Secondary Taxonomy Number (optional):

Physical therapists only: Does the provider provide services exclusively in a patient's home, in their personal home, in an institutional setting or a school setting? ☐ Yes ☐ No

Address information *(required)*

Service location – Enter the service location address where services are rendered. Address must be a physical street address (not a PO Box).

Note – *This is the address where a site visit may be conducted.*

- SPD Nursing Services *only*: Enter your home address as the service address. Do not use your client's address.

Physical address (include Room/Suite):	City:	State:	Zip Code:	+4:
County:	Phone:	Ext.:	Fax:	

Mail-To address – *Enter only if this address is different from the service location address:*

Street or PO Box (include Room/Suite):	City:	State:	Zip Code:	+4:

Pay-To address – *Enter only if this address is different from the Mail-to address:*

Street or PO Box (include Room/Suite):	City:	State:	Zip Code:	+4:

License/certification information *(required, if applicable)*

This information is for *(check one)*: ☐ License ☐ Certification	Number:
Issue date:	Issuing board:
Expiration date:	Issuing state:

Enrollment contact – *missing contact may delay processing*

Enrollment Contact name:	Contact email:
Contact phone number:	Contact fax number:

EFT financial contact – only

Complete this section with the contact information for the individual who can be contacted for financial related questions / validation.

Contact name:	Contact email:
Contact phone number:	Contact fax number:

Medical records contact – only

Complete this section with the contact information for the individual who can be contacted for medical records as needed for audit purposes.

Contact name:	Contact email:
Contact phone number:	Contact fax number:

Billing contact – only

Complete this section with the contact information for the individual or organization who can be contacted regarding billing and claims.

Contact name:	Contact email:
Contact phone number:	Contact fax number:

Clinical Laboratory Improvement Amendments (CLIA) – *(if applicable)*

If laboratory services are used at the facility, enter the laboratory's CLIA number and attach a copy of the current CLIA certification letter. **CLIA number:**

Adult Foster Homes - *only (required)*

Under section 1615(c) of the Social Security Act (Medicaid Waiver payments), you may be qualified to have certain Medicaid payments be excludable from income. Please carefully review information provided on www.irs.gov for more information about this Medicaid Waiver payment.

The link below has been provided as a starting point for your review.

https://www.irs.gov/individuals/certain-medicaid-waiver-payments-may-be-excludable-from-income

Based on information provided at www.irs.gov do you meet the qualifications for Medicaid Waiver payments? ☐ Yes ☐ No

Please be aware that if you mark "yes" and you do not meet the qualifications for the Medicaid Waiver payment, you may be subject to a Provider Sanction under OAR 410-120-1400 and OAR 410-120-1460.

Outpatient Behavior Health (MH / SUD) – *only (required)*

Is your facility/organization comprised exclusively of Oregon licensed practitioners? If yes, attach a list of practitioners that includes their name, NPI and license number.

☐ Yes ☐ No (see below for requirements)

If you employ or contract with unlicensed staff such as QMHA, QMHP, CADC's or Student (Master's level) Interns you must be certified in accordance with OAR 309-008 and 415-012. ***attach copy of OHA Certificate of Approval (COA) issued by HSD (formerly AMH)***

Note: *pursuant to OAR 410-172-0660, board-registered interns do not need a COA for enrollment purposes.*

If you have questions about the certification process, contact the Licensing and Certification Unit. Find current contact information at

http://www.oregon.gov/OHA/HSD/AMH-LC/Pages/Contacts.aspx.

Out-of-state providers: In accordance with OAR 410-172-0660, If the facility/organization is providing behavioral health services, only staff licensed by an Oregon Board may serve an Oregon Medicaid Member. In addition, the facility/organization may enroll only if it's comprised exclusively of health care practitioners or behavioral health care practitioners as outlined in OAR 309-008-0250(4)(b).

ABA Organizations – *only (required)*

ABA organizations are required to have a licensed therapist that all providers are practicing under in accordance with OAR 410-172-0760. ***Attach copy of BCBA license of the designated licensed therapist for this location.***

Should the designated licensed therapist change, it is your responsibility to notify OHA of this change and provide a copy of the license to support this change.

Polygrapher – *only (required)*

A sex offender polygrapher examiner specialist must have a general working knowledge of sex offenders, victims, treatment techniques, and ethical obligation as evidenced by one of the following.

☐ Participation and successful completion of an approved training offered by Oregon Adolescent Sex Offender Treatment Network ***(attach certificate of completion)****;* or

☐ Participation in an approved training pertaining to the treatment of sex offenders ***(attach documentation of attendance and successful completion)***; or

☐ A letter from a licensed therapist or counselor who provides treatment to sex offenders, attesting to your knowledge as described above ***(attach copy)***.

Enrollment effective date – *(for new providers and inactive providers only)*

Effective date requested for this enrollment (mm/dd/yyyy):

The effective date may be backdated up to one year from date received. If no effective date is provided, date of receipt will be used. Updates are effective the date received, and revalidation effective date is dependent on all information requested being received complete and accurate.

Provider or authorized representative 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.

Print name of Provider or representative

Title

Signature of Provider or representative

Date

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Equity and Inclusion Division at languageaccess.info@odhsoha.oregon.gov or 1-844-882-7889. We accept all relay calls.

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 Rule 943-120 and 410-120, as a condition of delivering health services to OHP members.

All providers including non-payable (non-billing), payable (billing), individuals and organizations must fill out and sign this Agreement and all other required documents to receive an OHP provider number from OHA. An OHP provider number must be issued before a claim or encounter for delivered health services or goods is sent to OHA for payment.

The type of providers enrolled by OHA are defined in OAR 410-120-1260 and include billing agents, managed care entities (MCEs) and other providers who order, refer or prescribe services or goods.

Provider name _____ National Provider Identifier (NPI) _____

Scope of Agreement

This Provider Enrollment Agreement sets forth the rights, responsibilities, terms and conditions governing provider participation in the Oregon Medicaid program. Per OAR 410-120-1260(17), the provision of health care services or items to OHP clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

To be eligible for enrollment, a provider must:

A. Complete and submit an Enrollment Application
B. Agree to and sign this Provider Enrollment Agreement (Agreement)
C. Complete, sign and submit a Medicaid Provider Disclosure Statement (organizations and billing providers only)

D. Be an eligible provider and meet the conditions in (OAR) 410-120-1260 and any rules directly related to the provider's service category and OHA program in effect on the date of enrollment, and,
E. Meet all the applicable state and/or federal licensure or certification requirements to assure OHA provider meets minimum qualifications to perform services under this Agreement. This includes maintaining a professional license or certification in good standing and compliance with all program rules and rules related to providers service category.
F. Pass all mandatory screening and validation steps.
G. This Agreement becomes effective the date approved by OHA for date requested on initial application.
H. For revalidation and any other circumstances, this Agreement becomes effective the date signed by Provider.
I. Failure to comply with the terms of this Agreement or any applicable CFR or OAR may result in termination, sanction(s) or payment recovery, subject to Provider appeal rights, pursuant to OHA rules.

Governance

Oregon's Medicaid program is authorized and governed by:

- Title XIX of the Social Security Act
- Title XXI of the Social Security Act
- Chapter IV and V of Title 42 of the Code of Federal Regulations (CFR);
- Oregon Revised Statue (ORS) 414;

This Agreement is governed by federal law pertaining to the Medicaid program and the laws of Oregon that include: OAR Chapters 410, 943 and any OAR applicable to provider's service category, e.g. Mental Health.

OHA's administrative rules are posted and available at all times on OHA's website and Oregon's Secretary of State (SOS) website. Federal regulations are posted and available at all times on Electronic Code of Federal Regulations (eCFR) and Federal Register websites. It is the provider's responsibility to become familiar with and abide by these rules.

Assurances

As an OHP provider, hereafter known as "Provider," and as a condition of payment for goods or services under this Agreement, you agree to:

Comply with applicable laws

A. Comply fully with all federal, state and local laws, rules, regulations, and statements of OHA policy applicable to the care, services, equipment or supplies including but not limited to OAR 410-120-1380, 410-172, 410-173, and this Agreement. Failure to comply with the terms of this Agreement or OHA rules may result in sanction(s) and/or payment recovery, which may also result in termination pursuant to federal regulation, OHA rule, and any contract(s) between the Provider and OHA.

B. Provider shall at all times be qualified, professionally competent and actively licensed where required by law to perform work under this Agreement.
C. Provider is not in violation of any Oregon Tax Laws. For purposes of this PEA, "Oregon Tax Laws" means a state tax imposed by ORS 320.005 to 320.150 and 403.200 to 403.250 and ORS chapters 118, 314, 316, 317, 318, 321, and 323, and the elderly rental assistance program under ORS 310.630 to 310.706 and local taxes administered by the Department of Revenue under ORS 305.620.

Disclosure

Provider understands and agrees that:

A. The information in the enrollment form(s) and all supporting documentation is true, accurate and complete. Information disclosed by a Provider is subject to verification. OHA will use this information for administration of the Oregon Medicaid program.
B. Loss, suspension or restriction of licensure, or certification, may result in immediate disenrollment.
C. Any deliberate omission, misrepresentation or falsification of information in enrollment form(s) or in any communication supplying information to OHA may be prosecuted under state or federal law.
D. All providers that request to enroll or are already enrolled are subject to additional screening by OHA at any time. Additional screening includes, but is not limited to, pre and post enrollment site visits and fingerprint and criminal background check.
E. Provider is not excluded or otherwise prohibited from participating in Medicare or any state Medicaid or CHIP programs. Provider has not been convicted of a criminal offense related to Medicare, Medicaid, CHIP or any federal agency or program.
F. Provider is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Non-procurement Programs" currently found at https://www.sam.gov/portal/public/SAM/. Provider will not use public funds to support, in whole or in part, the employment of individuals in any capacity having contact with Medicaid eligible individuals who have been convicted of a crime as identified under ORS 443.004(3), are on the Office of Inspector General (OIG) list of excluded individuals or entities, on the System Award Management (SAM) exclusion list, or the Data Exchange (DEX).

Services

Provider understands and agrees that:

A. The Provider agrees that all health care, services, equipment or supplies billed to Medicaid must be medically necessary, a covered service as defined in OAR Chapter 410, and provided in accordance with all applicable provisions of statutes, rules and federal regulations governing the reimbursement of services or items under OHP in effect on the date of service. Rules for OHP services are listed in OAR 410-120-1160 and defined in OAR Chapter 410 and Chapter 309. Provider further agrees to:
   a. Provide services within the parameters permitted by the Provider's license or certification and agrees to bill only for the services performed within the specialty or specialties designated in the Provider application on file OAR 410-120-1260. The services of goods must have been actually provided to the OHP member by the Provider prior to submitting a claim or encounter to OHA.
   b. Provide all services under this Agreement as an independent contractor. Provider is not an "officer," "employee" or "agent" of OHA, as the term is used in ORS 30.265.

B. Provider is responsible for verification of client OHP eligibility and benefit coverage and following applicable prior authorization requirements before rendering services as required in OHA Rules and described in OAR 410-120-1140.

Recordkeeping and access to records

Provider understands and agrees to:

A. Keep such records as are necessary to fully disclose the specific care, services, equipment or supplies provided to OHP members for which reimbursement is claimed, at the time it is provided, in compliance with the applicable OHA rules and federal regulations in effect on the date of service. Provider is responsible for the completeness, accuracy and secure storage of financial and clinical records and all other documentation of the specific care, services, equipment or supplies for which the provider has requested payment as required by OAR 410-120-1360, 410-172-0620, 410-173-0045, and any program specific rules in OAR Chapter 410 and Chapter 309.

B. Provide upon request by either OHA, the Program Integrity Audit Unit (PIAU), the Office of Payment Accuracy and Recovery (OPAR), the Oregon Secretary of State's Office, Federal Government, and the Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU), or any duly authorized representatives, immediate access to review and make copies of any and all records relied on by Provider in support of care, services, equipment or supplies billed to the Oregon medical assistance program. The term "immediate access" means access to records at the time the written request is presented to the Provider.

Communication

Provider understands and agrees that:

Any communication or notices from the Provider shall be given in writing via personal delivery, fax, email or regular mail, postage prepaid to OHA. Provider must notify OHA of any changes to Provider's information such as, address, name, licensure, within 30 days of the date of the change.

Confidentiality

Provider understands and agrees to:

Comply with the Health Insurance Portability and Accountability Act (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, and federal regulations at 45 CFR Parts 160 and 164, and as amended. The Provider specifically acknowledges their obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations. Provider agrees to comply with requirements for identifying, addressing and reporting an incident or breach, regardless of whether the incident or breach was accidental or otherwise.

Security

Provider understands and agrees that:

The Provider represents and warrants that the Provider will establish and maintain privacy and security standards and practices that respect and safeguard the privacy and security of all information related to OHA and the agency's employees, equipment, providers, systems and service recipients, regardless of media. Provider shall ensure the proper handling, storage and disposal of all information accessed, created, obtained, reproduced, or stored by the Provider and its authorized users using privacy and security standards that meet or exceed standards set by laws, rules, and regulations in (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, OAR Ch 943, the Oregon Consumer Identity Theft Protection Act, ORS 646A.600 through 646A.628, and Oregon's Statewide Information Security Standards, applicable to the information exchanged by the Provider and OHA or received by the Provider as a servicer of this Agreement. Provider shall ensure proper disposal of equipment and information assets when authorized use ends, consistent with Provider's record retention obligations and obligations regarding information assets under this Agreement.

Accurate billing

Provider understands and agrees that:

A. All claims or encounters submitted to OHA must be certified by signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the care, service, equipment or supplies claimed were actually provided, medically appropriate, documented at the time they were provided, documented using required diagnosis (ICD-10-CM) and procedure codes (HIPAA), and were provided in accordance with professionally recognized standards of health care, OAR 410-120-1280 through 1340 and this Agreement.

B. The Provider or its contracted agency, including billing providers, shall not submit or cause to be submitted:
    a. Any false claim for payment;
    b. Any claim altered in such a way as to result in a payment for service that has already been paid;
    c. Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exceptions described in OAR 410-120-1280. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to OHA. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code; or
    d. Any claim for furnishing specific care, items, or services that has not been provided.
C. The Provider is responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's responsibility for the claims or encounters submitted on Provider's behalf. OHA may recover any overpayment(s) that OHA made to Provider, by withholding future payment(s) or other processes as authorized by law or Agreement. If Provider fails to correct billing practices after written notice by OHA of non-compliance with state rules will be liable for up to triple the amount of identified overpayment(s).

Payment

Provider understands and agrees that:

A. Provider will accept OHA's payment as complete remuneration the amount paid in accordance with the reimbursement rate for services covered under OHP, except where payment by the client is authorized in the OARs. Payment will only be made to the enrolled provider who actually performs the service or to the Provider's enrolled billing provider for covered services rendered to eligible clients, OAR 410-120-1340.
B. OHA has sufficient funds currently available and authorized to make payments under this Agreement within OHA's biennial budget. Provider further understands and agrees that payment for services performed after the current biennium is contingent on OHA receiving from the Oregon Legislature appropriations or other expenditure authority sufficient to allow OHA, in its reasonable administrative discretion, to continue to make payments.
C. Provider must not bill OHP members for any services unless authorized by Oregon Administrative Rule.
D. Any overpayment made to Provider by OHA may be recouped by OHA as authorized by law including, but not limited to withholding of future payment to Provider. Provider's failure to perform the work specific in the Agreement or to meet the performance standards established in this Agreement, may result in consequences that include, but are not limited to reducing or withholding payment; requiring Provider to perform at Provider's expense additional work necessary to meet performance standards; and pursuing any available remedies for default including termination of this Agreement.
E. Provider is not an officer, employee or agent of OHA and shall not be deemed for any purpose an employee of the State of Oregon. The Provider shall perform all work as an

independent contractor, as defined in ORS 670.600, and is responsible for determining the appropriate means and manner of performance. Provider is responsible for all federal and state taxes applicable to compensation paid to Provider under this Agreement and, unless Provider is subject to backup withholdings, OHA may withhold from such compensation any amounts to cover Provider's federal or state tax obligations. Provider has no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency would prohibit Provider's work under this Agreement. Provider certifies it is not currently employed by the federal government.

F. OHA and Provider are the only parties to this Agreement and are the only parties entitled to enforce its terms. The parties agree that Provider's performance under this Agreement is solely for the benefit of OHA to accomplish its statutory mission. Nothing in this Agreement gives or shall be construed to give or provide any benefit or right, whether directly or indirectly to third persons that are any greater than the rights and benefits enjoyed by the general public.
G. As a condition of payment, Provider must meet and maintain compliance with the Provider enrollment and payment rules OAR chapter 410, division 120; 42 CFR 455.400 through 455.470, as applicable; and 42 CFR 455.100 through 455.106.

Discrimination

Provider understands and agrees to:

A. Comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.
B. Not discriminate against minorities, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts.
C. Provide services to Medicaid-eligible individuals without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability (as defined under the Americans with Disabilities Act). Medicaid services must reasonably accommodate the cultural, language and other special needs of the member.

Compliance with applicable laws

Provider understands and agrees that:

A. Provider shall comply and require all subcontractors to comply with federal, state and local laws and regulations, executive orders and ordinances applicable to items and services under this Agreement, including but not limited to OAR 407-120-0325, as they are amended from time to time. Without limiting the generality of the prior sentence, the Provider expressly agrees to comply and require all subcontractors to comply with all of the laws, regulations and executive orders listed under OAR 410-120-1380 to the extent they are applicable to the items and services provided under this Agreement.

B. Provider agrees that if any term or provision of this Agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected and the right and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.

Duration and termination of Agreement

Provider understands and agrees that:

A. This Agreement shall remain in effect for no more than five years from the effective date. OHA may terminate this Agreement at any time by written notice to the Provider by certified mail, return receipt requested, subject to any specific provider sanction requirements in OHA rules or Agreement(s) between OHA and the Provider.

B. OHA will terminate or suspend this Agreement if:
   a. The Provider or a person with 5 percent or greater direct or indirect ownership interest in the Provider, its agent or managing employee fails to submit timely, complete and accurate information, or cooperate with any screening requirements, unless OHA determines it is not in the best interests of the Medicaid program;
   b. Any person with a 5 percent or greater direct or indirect ownership interest in the Provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or title XXI program in the last 10 years, unless OHA determines it is not in the best interests of the Medicaid program;
   c. The Provider is terminated under title XVIII of the Social Security Act or under the Medicaid program or Children's Health Insurance Plan (CHIP) program of any state;
   d. The Provider or any person with a 5 percent or greater, direct or indirect, ownership interest in the Provider fails to submit sets of fingerprints in a form and manner to be determined by OHA within 30 days of a Centers for Medicare and Medicaid Services (CMS) or a OHA request, unless OHA determines it is not in the best interests of the Medicaid program;
   e. The Provider fails to permit access to Provider locations for any site visits under 42 CFR 455.432, unless OHA determines it is not in the best interests of the Medicaid program;
   f. CMS or OHA determines that the Provider has falsified any information provided on the application or if CMS or OHA cannot verify the identity of the Provider applicant.
   g. OHA fails to receive funding, appropriations, limitations or other expenditure authority at levels that OHA or the specific program determines to be sufficient to pay for the services or items covered under this Agreement;
   h. Federal or state laws, regulations or guidelines are modified, or interpreted by OHA in a manner that either providing the services or items under the Agreement is prohibited or OHA is prohibited from paying for such services or items from the planned funding source;
   i. OHA issues a final order revoking this Agreement based on a sanction under termination terms and conditions established in program-specific rules or policies, if required;

j. The Provider no longer holds a required license, certificate or other authority to qualify as a Provider. The termination will be effective on the date the license, certificate or other authority is no longer valid;
k. The Provider fails to meet one or more of the requirements governing participation as a OHA enrolled Provider. In addition to termination or suspension of the Agreement the Provider number may be immediately suspended in accordance with OAR 407-120-0360;
l. Provider commits any material breach or default of any covenant, warranty, or obligation under this Agreement, fails to perform the work under this Agreement or fails to pursue the work as to endanger Provider's performance under this Agreement in accordance with its terms;

C. Provider may terminate this Agreement at any time, subject to specific Provider termination requirements in OHA rules, OHA program-specific rules or federal regulations by submitting a written notice, in person, or by certified mail listing a specific termination effective date. The request must be in writing and signed by the provider. The notice shall specify the OHA-assigned provider number to be terminated and the effective date of termination. Termination of this Agreement does not relieve the Provider of any obligations for covered services or items provided for the dates of services during which the Agreement was in effect.

Insurance requirements

Required insurance: During the term of this Agreement, Provider shall possess any and all insurance required within the program rules based on Provider type and any business requirements set forth by the Department of Consumer and Business Services at Providers cost and expense. The insurance may include, but is not limited to, general liability, professional liability, malpractice, workers compensation, employer's liability, excess/umbrella insurance, tail coverage, etc. Provider must retain any and all certificate(s) and proof of insurance, notice of change or cancellation, insurance reviews, state acceptance or other actions on the providers insurance.

Upon request, Provider will provide to OHA not more than thirty (30) days of any change, reduction, suspension, cancellation or termination of Provider's insurance coverage required by this section.

OHA may exempt Provider from these requirements for any reason, including but not limited to the inability of Provider to procure such insurance.

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

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Provider Enrollment at provider.enrollment@odhsoha.oregon.gov or 1-800-336-6016 (voice). We accept all relay calls.