



MEDICAL OFFICE PROVIDER ENROLLMENT FORM

Please complete and return via email to linda.sheer@trizetto.com If you are unable to email this form, please fax it to 314-802-6913.

Contact Name:	Phone:
Email:	Fax:

The information provided on this form MUST match what is on file with the payers.

Group Information (if applicable)	Provider Information
Group Name:	First Name:
	MI:
DBA (if applicable):	Last Name:
	Title:
Group NPI:	Individual NPI:
Tax ID:	Specialty:

Service Location Address	Pay To Address (if different)
Street Address:	Street Address:
City, State, Zip +4:	City, State, Zip +4:

^{***}Indicate below the Individual and/or the Group Provider numbers, legacy ID's or PTANS issued by the payers. ***
Although these IDs may not be used on the claims, they are often required for EDI enrollment.

Insurance Company	Payer ID	Group Provider Number	Individual Provider Number
Southwest Orgegon IPA / Western Oregon Advanced Health	DOCSO		





SOUTHWEST OREGON IPA / WESTERN OREGON ADVANCE HEALTH ENROLLMENT FORM

Please complete and return via email to linda.sheer@trizetto.com If you are unable to email this form, please fax it to 314-802-6913.

Provider/Facility Name	
Tax ID	
Oregon Medicaid Provider ID	
6 digit Medicare Provider ID Number	
for the Facility (1C Medicare Number)	
Vendor (The vendor is the clinic where	
the payment is to be issued to)	
Physical Address	
Billing Address	
Contact Name	
Contact Phone Number	

If you have questions regarding the required ID's for this enrollment, please contact the payer at 541-269-7400 Ext 122.