

Medical-Surgical Services Provider Guide



Supplemental information for
Oregon Medicaid providers

- Prior authorization
- Billing instructions, forms and codes
- Electronic billing / EDI
- Forms: Consent forms, Maternity Case Management, Lead Risk Assessment
- Pharmaceutical references
- Fluoridated water systems



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NOTE: DMAP provides the Information and instructions contained in this booklet as a supplement to the program policies found in the current Medical-Surgical Services Oregon Administrative Rules (Chapter 410 Division 130). See current Medical-Surgical Services rulebook for official policies regarding billing.

Service eligibility

Client eligibility and enrollment

DMAP General Rule 410-120-1140 Verification of Eligibility and Coverage requires all enrolled providers to verify eligibility on the date of service.

- DMAP will not pay claims for clients who are not eligible on the date of service.
- For clients enrolled in an OHP managed care plan, DMAP will not pay for services covered by the managed care plan, except as provided by statute and included in Oregon Administrative Rule (OAR).

Resources

To determine client eligibility and enrollment, verify with one of the following. For more information about these options, go to www.oregon.gov/OHA/healthplan/tools_prov/electronverify.shtml.

- Automated Voice Response (AVR): Call 866-692-3864. A quick reference for verifying client eligibility via AVR is available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE3162.pdf>.
- Provider Web Portal: Go to <https://www.or-medicaid.gov>.
- 270/271 transaction: Available to approved Electronic Data Interchange (EDI) providers.

Prior authorization (PA) - See OAR 410-130-0200 for services that require PA

Table 410-130-0200-1 in the Medical-Surgical Services rulebook (OAR 410 Division 130) lists services requiring PA.

How to submit PA requests

For clients enrolled in an OHP managed care plan, contact the plan for their PA procedures. For OHP fee-for-service (“open card”) clients, use the following contact information:

Professional services

Use the DHS 3971 form or the Provider Web Portal to submit PA requests. For information on how to submit PA requests using the Provider Web Portal, go to www.oregon.gov/OHA/healthplan/webportal.shtml#authorization.

Submit documentation for PA requests using the following fax numbers:

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

Fax required documentation accompanied by the EDMS Coversheet (DHS 3970). See Forms section for sample forms and instructions.

If you have questions about how to request PA, contact.

DMAP Medical Management Unit

500 Summer St NE, E44
Salem, OR 97301-1078

503-945-6821 (direct)
800-642-8635 (in-state only)

Pharmaceutical services and oral nutritional supplements

Submit all PA requests for fee-for-service prescriptions (including 7/11 carveout drugs for managed care plan clients) and oral nutritional supplements to:

Oregon Pharmacy Call Center

888-202-2126
Fax: 888-346-0178

Use the DMAP 3978 form (see Forms section for sample and instructions). Refer to the Pharmaceutical Services provider guidelines for more information about requesting PA.

Primary Care Management Services

Definitions

PCM-managed services

PCM case managed services include the following:

- Preventive services
- Primary care services
- Specialty services
- Inpatient hospital services
- Outpatient hospital services except laboratory, X-ray, and maternity management services

Preventive services

Those services as defined in OAR 410-141-0480, and 410-141-0860 of the *OHP (Managed Care) Administrative Rulebook*.

Primary Care Management services

Services provided to ensure PCM members maintain physical and emotional development and health. These services include a comprehensive ongoing assessment of medical needs and the development and implementation of a plan for PCM members to obtain services that are preventive or primary care, and follow-ups, as appropriate.

Primary Care Manager (PCM)

The PCM provides preventive and primary care services to PCM members for a case management payment. The PCM bills DMAP on a fee-for-service basis.

PCMs may be:

- Physicians (MD or DO).
- Nurse practitioners.
- Physician assistants.
- Naturopaths with physician backup.
- Hospital primary care clinics.
- Rural Health Clinics.
- Indian Health Service Clinics.
- Tribal Health Clinics.

PCM member enrollment

DMAP updates the PCM member's enrollee status and eligibility each night. Automated Voice Response and Provider Web Portal provide current client eligibility verification, the PCM's name, and phone number.

The Web portal provides the PCM member's PCM's name, address, and telephone number.

The *OHP Client Handbook*, sent to all new clients, contains a section explaining managed care.

Responsibilities

Capacity

Each PCM should set capacity based on the number of individuals in the current patient load eligible for the Oregon Health Plan (OHP) and any additional "room" in the practice for new patients under the OHP. Capacity may include many existing Medicaid patients.

The PCM adjusts capacity levels and may open or close enrollment at any time to meet capacity limitations.

Enrollment must be restricted to a defined service area (either a county or counties).

New patients

New PCM members are eligible for an initial visit. To bill for an initial visit, use the appropriate "New Patient" code under "Preventive Medicine Services" in the Evaluation and Management Services section of your current CPT.

If a new PCM member seeks emergency care and the PCM has not previously examined the patient or obtained prior medical history, the PCM may defer professional judgment and authority to the physician/practitioner treating the emergency.

PCMs are encouraged to establish a relationship with new PCM members.

Providing medically appropriate care

To ensure the availability and accessibility of services to PCM members, PCMs must have:

- Responsive appointment scheduling.
- Office hours and after-hours availability for emergency consultation.
- Reasonable provisions for interpretation to assist patients who do not speak English (when necessary and as available in the community).

Emergency care

PCMs must approve and authorize all emergency room care. PCMs must have 24-hour a day, 7-day a week coverage which includes after-hours telephone access for consultation about urgent/emergent care.

If a new PCM member seeks emergency care and the PCM has not previously examined the patient or obtained prior medical history, the PCM may defer professional judgment and authority to the physician/practitioner treating the emergency.

PCMs must provide or arrange for follow-up care as medically appropriate after emergency room care.

When medically appropriate, PCMs must arrange for office or clinic care as an alternative to emergency room care.

Substituting for a PCM

A substitute care case manager must agree to assume the role for the PCM when the PCM is temporarily absent from practice due to vacation, extended training, illness, etc.

Referrals

Services provided by the following providers require a referral from the PCM:

- Chiropractors
- Migrant and Community Health Clinics
- County Health Departments
- Federally Qualified Health Centers
- Indian Health Service and Tribal Health Clinics
- Medical Physicians
- Nurse Practitioners

- Osteopathic Physicians
- Physician Assistants
- Podiatrists
- Rural Health Clinics
- Naturopaths
- Hospital – Inpatient
- Hospitals – Outpatient, other than laboratory, X-ray, or maternity case management services

All claims requiring a PCM referral must list the PCM's six- or nine-digit Oregon Medicaid provider number in the appropriate box on the claim form.

Referral and authorization exemptions

DMAP will pay for the following services without a direct PCM referral:

- Anesthesiology
- Dental care
- Durable medical equipment
- Eye care (routine vision exams, dispensing services, and vision materials)
- Family planning services
- HIV prevention services
- Immunizations and treatment for communicable and sexually transmitted diseases provided by a publicly funded clinic
- Laboratory and X-ray services
- Maternity case management services
- Mental health and chemical dependency services
- Pharmacy services
- Physical and occupational therapy
- School-based services provided under an Individual Education Plan or an Individual Family Service Plan
- Speech and hearing services
- Targeted case management services
- Transportation

Although these services do not require a direct referral, they should be documented in the PCM member's medical record when the PCM makes a direct referral or when reported by the specialty care provider or PCM member.

PCM members should be encouraged to report all medical treatment to their PCM.

Claims submitted by PCMs

PCMs must submit claims according to DMAP's Administrative Rules for medical services provided. Refer to the appropriate provider guidelines for specific instructions.

DMAP will send a remittance advice showing specific payments and other claims actions. Medical services will be paid at a fee-for-service rate for services covered under the OHP.

The PCM will automatically receive a monthly case management fee from DMAP for each PCM member.

Billing information

National Provider Identifier

To ensure accurate and timely claims processing, DMAP requires all providers to register their National Provider Identifier (NPI) and taxonomy code(s) with DMAP.

To find out if you need a National Provider Identifier, or how to obtain one, go to the DMAP NPI Web page at www.oregon.gov/OHA/healthplan/tools_prov/npis.html.

Billing for surgeries

All surgeries must be billed on one claim, whether the codes need prior authorization (PA) or not.

- If there is not enough space on the CMS-1500 to bill all surgical procedures provided on the same date of service, submit the claim electronically (837P or Provider Web Portal). List prior authorized codes first.
- Non-surgical procedures provided on the same date of service can be billed on a separate claim form.

Claims for services that require prior authorization

Make sure all services requiring prior authorization are billed on a single claim. If a service is later billed for the same date range, DMAP will deny the claim as a duplicate service already paid.

The system does not look at the PA number field on claims to find the PA. Instead, it looks for PAs that have an exact match to the following on the claim (if applicable):

- Diagnosis code
- Procedure code
- Performing provider

If the system cannot find an approved PA that matches these items on your claim, or if the degree of specificity does not match for any item on a potential match, the claim will deny.

To avoid this, look up the existing PA on the Provider Web Portal before you bill. Then you can make sure you bill for the service using the same criteria listed in the PA.

Please continue to record the 10-digit PA number in the PA number field of claims submitted to DMAP. Even though the system does not use this field during claim processing, this number helps DMAP staff resolve the claim when the system cannot find a matching PA.

Medication Therapy Management (MTM)

Pharmacists must enroll with DMAP as a professional provider to bill for MTM services. Services must be provided based on referral from a physician, licensed provider, or a Prepaid Health Plan (PHP). Use the following codes to bill for MTM services:

Code	Description	DMAP rate
99605	Initial 15 minutes, new patient	\$28.22
99606	Initial 15 minutes, established patient	\$26.34
99607	Each additional 15 minutes.	\$13.17

When to bill on paper

You must bill on paper for claims that require attachments, reports or manual pricing (*e.g.*, unlisted procedure codes). Submit the paper claim with a cover letter and required documentation attached.

Electronic claims submissions

DMAP accepts professional claims in the following electronic formats:

Batch claim format

If you want to submit claims electronically using the 837P format, you must become an approved Electronic Data Interchange (EDI) provider. To begin the authorization process, contact EDI Support Services:

E-mail: DHS.EDIsupport@state.or.us

Phone: 888-690-9888

Web site: www.oregon.gov/OHA/edi

Coordination of Benefits (COB)

The 837 professional transaction will allow you to send COB/secondary payer claims. This means that if you have a claim that Medicare, or any other insurer, has paid as primary, you can use the 837 transaction to report the other insurance and bill DMAP as secondary.

For more information, contact EDI Support Services (see above).

Transaction information for EDI submitters

The Oregon Medicaid Companion Guides contain information on how registered EDI submitters need to set up and code their transactions for appropriate processing by DMAP.

- For specific instructions on how to submit an electronic claim, refer to the *Oregon Medicaid 837 Professional Companion Guide - Fee-for-Service* at www.oregon.gov/OHA/edi/resources.shtml.
- If you bill for multiple service locations, submit your taxonomy and the complete ZIP+4 code in your 837 submission to ensure payment to the appropriate service location.

Individual claim format

Enrolled DMAP providers authorized to access the Provider Web Portal can submit individual professional claims at <https://www.or-medicaid.gov>.

For more information, go to www.oregon.gov/OHA/healthplan/webportal.shtml.

Paper claim submissions

DMAP only accepts current, commercially available versions of paper claim forms.

DMAP will return all other formats with a request to resubmit the claim in a valid claim format (Web, EDI, or commercially available form).

The information listed on the following pages is necessary for processing paper claims. You can enter information in more than the required fields, but **only** the information in the required fields is absolutely necessary (unless otherwise noted).

- Check your claim for missing, incorrect or misaligned information before it's mailed. Claim processing depends upon how well your claim is completed.
- **Each claim is a complete billing document.** Do not submit multi-page claims. If you do not have enough space on the form to bill all procedures provided, complete a new billing form for the rest of the procedures, or use the Provider Web Portal. Do not “carry over” totals from one claim to another.
- Use a separate claim form for each client.

Health Insurance Claim Form (CMS-1500)

DMAP does not supply this form. This federal form is available through local business forms suppliers, the Oregon Medical Association, or by calling the U.S. Government Printing Office at 1-866-512-1800.

Make sure information is left-aligned in the following fields:

- 1a - Client ID
- 2 - Patient Name
- 24A - Dates of Service - For detail line 1 only

If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

Where to mail claims

Send all completed CMS-1500 forms to:

DMAP
PO Box 14955
Salem, OR 97309

8/05 CMS 1500 claim form instructions

General instructions for this form can be found on the National Uniform Claim Committee (NUCC) Web site at www.nucc.org/content/view/33/42/.

- Shaded boxes indicate the fields DMAP uses to process your claim (shaded on next page). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed.
- Unshaded fields are optional or required only in certain circumstances.
- Make sure information is left-aligned and correctly placed in fields marked “***Left-align.***” Misaligned information in these fields will delay processing.

1a.	The eight-digit number found on the Medical Care ID. <i>Left-align</i>
2.	The client’s name as it appears on the Medical Care ID. <i>Left-align</i>
9.	Use Third Party Resource codes to indicate response received from other resources. Be sure that this code is the first entry in Field 9, followed by the name of the TPR. <ul style="list-style-type: none"> ◆ If the client has other health coverage, and no payment was received from that resource, this space must be used to explain why no payment was made. ◆ If using TPR code “MO” or “OT,” write “Review TPR code” at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301.
10a-10c.	Complete as appropriate when an injury is involved.
17.	Enter the name of the referring physician.
17a.	Enter the Oregon Medicaid provider number for the referring physician. This information may be required if: <ul style="list-style-type: none"> ◆ Your client has a Primary Care Manager (PCM), or ◆ The service being billed requires a referral (<i>e.g.</i>, therapy services).
17b.	Enter the PCM or referring physician’s 10-digit National Provider Identifier (NPI).
21.	Enter the principal diagnosis/condition of the client indicated by current ICD-9-CM code number. Enter up to four codes in priority order. <ul style="list-style-type: none"> ◆ Carry the codes out to their highest degree of specificity (fourth or fifth digit).
23.	If the service being billed requires prior authorization, and DMAP has authorized the service, enter the 10-digit PA number here.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY STATE					TELEPHONE (Include Area Code)														
ZIP CODE TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE TELEPHONE (Include Area Code) ()																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____																			
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 21 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
23. PRIOR AUTHORIZATION NUMBER																													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #									
24A		24B				24D				24E		24F		24G				24J											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 28					29. AMOUNT PAID \$					30. BALANCE DUE \$ 30				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # () 33									
SIGNED _____ DATE _____																													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

24.	<p>In the shaded area across Fields 24A through 24H, enter supplemental information (<i>e.g.</i>, NDC, anesthesia) about the service. Enter the appropriate qualifier(s), followed by the information.</p> <ul style="list-style-type: none"> ◆ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. See page 24 for more information about entering supplemental information. ◆ If billing for physician-administered drugs: Enter National Drug Code (NDC) information in the following order: N4, 11-digit NDC in 5-4-2 format, one space, unit of measure, NDC quantity (limited to 8 digits before the decimal and 3 digits after the decimal). If entering a whole number, do not use a decimal. Do not use commas. See the example below:
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24. A. DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER						
N4	12345678901	UN	1234	567										123456789	
MM	DD	YY	MM	DD	YY	1		J#####	UD [for 340B drugs]	1	###	##	20	NPI	1234567890

24A.	<p>Enter the date (or first and last dates if consecutive days) that the service was provided. Must be numeric (100308). If “From-To” dates are used, a service must have been provided on each consecutive day but not more than once per day.</p> <p>Left-align for line item 1</p>
24B.	<p>Enter the appropriate code for the place service was provided: Use current Medicare place of service codes (available on the CMS Web site at www.cms.hhs.gov/PlaceofServiceCodes/ or CPT/HCPCS book).</p>
24C.	<p>Put a “Y” in this field if the service was an emergency. Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency.</p>
24D.	<p>Enter the most appropriate CPT or HCPCS code as described in the Medical-Surgical Services rulebook (OAR Chapter 410, Division 130). See page 20 for accepted modifiers.</p> <ul style="list-style-type: none"> ◆ For physician-administered drugs: Enter Modifier UD for drugs purchased for Medicaid clients through a 340B entity.
24E.	<p>Enter the one-digit line number which refers to the primary diagnosis from Field 21 for each service billed.</p>
24F.	<p>Enter the charge for each service billed.</p>
24G.	<p>Enter the number of days or units. This number must match the number of days in Field 24A or the number of units of service provided.</p> <ul style="list-style-type: none"> ◆ For instructions on entering multiples of the same surgical code, see OAR 410-130-0380.
24H.	<p>Enter a “Y” if the service is related to family planning or EPSDT.</p>

24I.	Leave this field blank. If you include a qualifier on the line for the Oregon Medicaid provider number, the system reads the qualifier as part of the provider number and denies the claim due to invalid provider number.
24J.	In the shaded half of this field, enter the 6- or 9-digit Oregon Medicaid provider number of the provider who rendered the service. Do not enter an NPI. <ul style="list-style-type: none"> ◆ For Medication Therapy Management services: Enter the pharmacist's Oregon Medicaid provider number.
26.	(Optional) Enter your unique patient account number here (up to 12 characters). It will be printed on your remittance advice.
28.	Enter the total of all of the charges listed in column 24F.
29.	Enter the total amount paid by any other insurance or resource. Do not include DMAP copayments in this Field. If the client has other insurance and this amount is zero, there must be a 2-digit "reason" code in Field 9.
30.	Enter the amount due after subtracting the Amount Paid from the Total Charge (Field 28 minus Field 29). Do not include insurance write-off amounts.
33.	If you have an NPI, enter it in part "a" of this field. In part "b," enter your Oregon Medicaid provider number and do not enter qualifiers (<i>e.g.</i> , 1D) before the provider number. <ul style="list-style-type: none"> ◆ These numbers identify the provider to whom the check should be sent (actual service provider <i>or</i> the provider's billing service). ◆ If you leave part "b" blank, DMAP will use the NPI in part "a" to process your claim, which may result in DMAP processing the claim under the wrong Oregon Medicaid provider number. ◆ Do not enter qualifiers in these fields. If you enter a qualifier, the system will read it as part of the provider number and deny for invalid provider number.

DMAP 505 – Medicare / Medicaid Billing Invoice

To order this form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310. You will find a copy of the DMAP 2420 in the Forms section of this supplement.

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE0505.pdf>.

Where to mail claims

Send all completed DMAP 505 forms to:

DMAP
PO Box 14015
Salem, OR 97309

How to complete the DMAP 505

Shaded boxes indicate the fields DMAP uses to process your claim (shaded on next page). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed. Unshaded fields are optional or required only in certain circumstances.

1.	Enter the client's name as printed on the Medical Care ID.
3.	Enter the 8-digit number found on the Medical Care ID.
8.	Enter the Medicare claim number as it appears on the client's Medicare card.
9.	<p>If no payment was received from Medicare, use this space to explain why no payment was made. Enter a 2 digit "reason" code from the Third Party Resource (TPR) codes on pages 22-23, followed by the name of the TPR (Medicare).</p> <ul style="list-style-type: none">◆ If there is any other TPR, be sure to use a code that shows what both insurances did.◆ If using TPR code "MO" or "OT," write "Review TPR code" at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301.
7.	Complete ONLY when an injury is involved.
14.	Complete if the service was performed as an emergency. Labor and delivery services for Citizen/Alien-Waived Emergency Medical (CAWEM) women are considered an emergency.
16a.	Enter the 6- or 9-digit Oregon Medicaid provider number of the referring (requesting) practitioner.
16b.	Enter the 10-digit National Provider Identifier (NPI) of the referring practitioner.



Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, 1)		2. Patient's birthdate/sex MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		3. Insured's ID # (include all letters and numbers) 3	
4. Patient's address (number, street)		5. Patient's Relation to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. Insured's Name (Last, First, MI)	
City	State	7. Was condition related to: a. Patient's employment Y <input type="checkbox"/> N <input type="checkbox"/> b. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/>		8. Insured's address (number, street)	
Zip Code	Phone (Area Code)			City	State
9. Other insured's name (Last, First, MI)		a. Other insured's Plan name		Zip Code	Phone (Area Code)
Other insured's Plan address (number, street)		b. Other insured's policy number		10. Insured's group # (or group name)	
City	State	Zip Code	Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below. <i>Signed (insured or authorized person)</i>	
11. Patient's or authorized person's signature – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. <i>Signed</i> _____ <i>Date</i> _____					
13. Date of current: MM DD YY		14. If emergency, check here <input type="checkbox"/>		15. First date patient had same or similar illness MM DD YY	
16. Name of referring provider or other source		16a. _____		17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY	
16b. NPI					
18. Outside lab? Yes <input type="checkbox"/> No <input type="checkbox"/>		\$ Charges		19. Prior authorization number 21	
20. Hospitalization dates related to current services From MM DD YY To MM DD YY					
21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by 1. _____ 2. _____ 3. _____ 4. _____) 21					
22. A. Date(s) of service MM 22A To MM DD 22B	B. Place of service	C. Procedures, services or supplies (expl. usual circumstances) CPT/H 22C	D. Diagnosis or units 22D	E. Days 22E	F. EPSDT Family Plan 22G
					G. Charges and Medicare 22H
					H. Medicare's covered charges
					I. Rendering DHS Provider Number
					DHS: _____
					NPI: _____
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					DHS: _____

19.	If the service requires prior authorization (PA), enter the 10-digit PA number issued by DMAP or the branch/unit.
21.	Enter the primary diagnosis/condition of the client indicated by appropriate ICD-9-CM code number. Enter up to four codes in priority order. Carry the codes out to their highest degree of specificity.
22.	<p>In the shaded area across Fields 22A through 22I, enter supplemental information (<i>e.g.</i>, NDC, anesthesia) about the service. Enter the appropriate qualifier(s), followed by the information.</p> <ul style="list-style-type: none"> ◆ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. See page 24 for more information about entering supplemental information. ◆ If billing for physician-administered drugs: Enter National Drug Code (NDC) information in the following order: N4, 11-digit NDC in 5-4-2 format, one space, unit of measure, NDC quantity (limited to 8 digits before the decimal and 3 digits after the decimal). If entering a whole number, do not use a decimal. Do not use commas. See the example below:

22.	A. Date(s) of service		B. Place of service	C. Procedures, services or supplies (explain unusual circumstances)		D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering DHS Provider Number
	From MM DD YY	To MM DD YY		CPT/HCPCS	Modifier						
	N412345678901 UN1234.567										DHS: 123456789
	MM DD YY	MM DD YY	1	J#####	UD [for 340B drugs]	1	20		### #	### #	NPI: 1234567890

22A.	Use a six-digit numeric date (MM/DD/YY). If a “From-To” range is used, all services must be on consecutive days and the quantity in Field 22E must equal the number of days.
22B.	Enter where service was provided: Use current Medicare place of service codes (available on the CMS Web site at www.cms.hhs.gov/PlaceofServiceCodes/ or CPT/HCPCS book).
22C.	Enter the appropriate procedure code plus any appropriate two-digit modifier(s).
22D.	Enter a single diagnosis reference number on each line as shown in Field 21.
22E.	Enter the number of services or units you are billing for.
22F.	Enter a “Y” in this field if the service relates to EPSDT or family planning.
22G.	Enter the total dollar amount billed to Medicare for each service.
22H.	Enter the dollar amount allowed by Medicare for each service.

22I.	<p>If not used in Field 31, enter your performing provider number information here.</p> <ul style="list-style-type: none"> ◆ In the top half of this field, enter the 6-digit Oregon Medicaid provider number. ◆ In the bottom half of this field, enter the 10-digit NPI.
24.	Add the charges in Field 22G and enter the total dollar amount Medicare was billed.
25.	Enter the total dollar amount paid by Medicare for the services. Do not show Medicare or other insurance write-offs.
26.	Optional. If your patient account number is entered here, DMAP will print the account number on the remittance advice.
28.	Enter any amount paid by any health insurance resource, other than Medicare. If the amount is zero, put in a “0.”
29.	Subtract the amounts in Fields 25 and 28 from Field 24 and enter the balance in this field. You must enter an amount in this field.
31	<p>If you have an NPI, enter it in the “NPI #” part of this field.. In the “DMAP #” part of this field, enter your Oregon Medicaid billing provider number.</p> <ul style="list-style-type: none"> ◆ These numbers identify the provider to whom the check should be sent (actual service provider <i>or</i> the provider’s billing service).

Billing codes

Where to find codes

Lists and instructions in the use of codes are in rule. See the Medical-Surgical Services rulebook (OAR 410 Division 130) for specific coding information.

To obtain a copy of the current rulebook, go to www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html, or call DMAP at 503-945-5772 or 800-527-5772.

Code books for ICD-9-CM, CPT, and HCPCS codes can be purchased from:

American Medical Association

PO Box 10950

Chicago, IL 60610

Phone: 800-621-8335

Web site: www.amapress.com

Or other reputable supplier

Third Party Resource (TPR) explanation codes

Use in Field 9 on the CMS-1500 and DMAP 505 forms. These codes can only be used on paper claims. They cannot be used on electronic claims submissions.

Single insurance coverage

Use a single insurance code when the client has only one insurance policy in addition to DMAP coverage.

- UD Service Under Deductible
- NC Service Not Covered by Insurance Policy
- PN Patient Not Covered by Insurance Policy
- IC Insurance Coverage Cancelled/Terminated
- IL Insurance Lapsed or Not in Effect on Date of Service
- IP Insurance Payment Went to Policyholder
- PP Insurance Payment Went to Patient
- NA Service Not Authorized or Prior Authorized by Insurance
- NE Service Not Considered Emergency by Insurance
- NP Service Not Provided by Primary Care Provider/Facility
- MB Maximum Benefits Used for Diagnosis/Condition
- RI Requested Information Not Received by Insurance from Client
- RP Requested Information Not Received by Insurance from Policyholder
- MV Motor Vehicle Accident Fund Maximum Benefits Exhausted
- AP Insurance mandated under administrative/court order through an absent parent not paid within 30 days
- OT Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Multiple insurance coverage

Use a multiple insurance code when the client has more than one insurance policy in addition to DMAP coverage.

- MP Primary Insurance Paid-Secondary Paid
- SU Primary Insurance Paid - Secondary Under Deductible
- MU Primary and Secondary Under Deductible
- PU Primary Insurance Under Deductible - Secondary Paid
- SS Primary Insurance Paid - Secondary Service Not Covered

- SC Primary Insurance Paid - Secondary Patient Not Covered
- ST Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
- SL Primary Paid - Secondary Lapsed or Not in Effect
- SP Primary Paid - Secondary Payment Went to Patient
- SH Primary Paid - Secondary Payment Went to Policyholder
- SA Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
- SE Primary Paid - Secondary Denied - Service Not Considered Emergency
- SF Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/
Facility
- SM Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/
Condition
- SI Primary Paid - Secondary Denied - Requested Information Not Received from
Policyholder
- SR Primary Paid - Secondary Denied - Requested Information Not Received from
Patient
- MC Service Not Covered by Primary or Secondary Insurance
- MO Other (if above codes do not apply, include detailed information of why no TPR
payment was made)

Modifiers

DMAP uses national standards for coding and recognizes all national modifiers. Use CPT and HCPCS guidelines for use of modifiers unless otherwise instructed below.

- 99 DMAP can only accept two 2-digit modifiers per line. For more than 2 modifiers, use modifier -99 in the first position. Place the most pertinent modifier in the next position, followed by all other modifier codes.

Supplemental information qualifiers

DMAP accepts the following types of supplemental information, accompanied by the appropriate qualifier:

Qualifier	Information Type
7	Anesthesia duration in minutes with start and end times
ZZ	Narrative description of unspecified codes
N4	National Drug Codes (NDC). In addition, use the following qualifiers when reporting NDC units: <ul style="list-style-type: none"> ◆ F2 – International Unit ◆ GR – Gram ◆ ML – Milliliter ◆ UN - Unit
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC)
CTR	Contract rate

The following examples show how to enter different types of supplemental information as listed above. They are not meant to provide direction on how to code for specific services.

Anesthesia Services – Payment based on 15-minute units

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.	
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
7Begin 1245 End 1415 Time 90 Minutes																	
06	01	07	06	01	07	1		00770	P2		1	###	##	6		NPI	1234567890

Unspecified Code

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.	
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
ZZ Kaye Walker																	
06	01	07	06	01	07	4		E1399			1	###	##	1		NPI	1234567890

Vendor Product Number

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
VPA122BIC5D6E7G																
06	01	07	06	01	07	1		A6410			1	##	##		NPI	1234567890

Remittance advice

The paper remittance advice (RA) tells you about payment, denial, or other actions taken on a claim. If you are expecting a paper check, you will find it on the third page of your RA. Claims “in process” (suspended) will also appear on your RA.

- The information you see on the RA is the information our system used to process your claim. If you receive an incorrect payment, you must adjust the claim using the Individual Adjustment Request (DMAP 1036) or Provider Web Portal. If DMAP made no payment, your RA will tell you to resubmit or adjust the claim.
- It is important to distinguish between a claim and an RA. You may receive one RA for many clients. Each line on the RA indicates an individual claim. One problem claim will not delay payment for the other claims listed on the RA.

For more information about the remittance advice, go to DMAP’s Remittance Advice Web page at www.oregon.gov/OHA/healthplan/tools_prov/read-ra.shtml.

Electronic remittance advice

Providers who submit electronic claims in the 837 format can choose to receive the 835 Fee for Service Payment/Advice transaction. Like the paper RA, the 835 transaction displays the number of claims and the adjudication status of your claims in Oregon’s Medicaid system. It does not contain suspended claim information.

The 835 contains HIPAA Claim Adjustment Reason Codes. A list of these codes can be found on the Washington Publishing Web site www.wpc-edi.com/content/view/180/223/. For more detailed codes, refer to the paper RA.

To sign up for the 835 transaction, contact EDI Support Services (see page 11).

Web portal claim search

Instead of waiting for the paper Remittance Advice to come in the mail, authorized providers can review previously submitted claims on the Provider Web Portal at <https://www.or-medicaid.gov> and adjust, void, or resubmit claims as needed.

For more information, go to the Provider Web Portal resources page at www.oregon.gov/OHA/healthplan/webportal.shtml.

Correcting claims

You have three options to adjust a claim that you submitted and DMAP processed:

- Send a paper DMAP 1036 Individual Adjustment Request (see the Forms section);
- Adjust the claim electronically using the Provider Web Portal; or
- Submit the 837P transaction (refer to the 837 Companion Guide).

If DMAP denied your claim, you can submit a corrected claim on paper, Web, or the 837.

Forms

All DMAP forms are available electronically on the Web at www.oregon.gov/OHA/healthplan/forms/omapforms.shtml.

DMAP 741 - Hysterectomy Consent

Do not use Consent to Sterilization forms (DMAP 742A and DMAP 742B) for hysterectomies. Hysterectomies for the sole purpose of sterilization are not covered.

Mail a copy of the completed form to:

DMAP
PO Box 14958
Salem, OR 97309-4958

For more information

See OAR 410-130-0580 for more information about hysterectomy consent procedures.

The *DMAP Hysterectomy and Sterilization Procedures Manual* contains more detailed information and tips not available in administrative rules.

This resource is available in the “Supplemental Information” section of the Medical-Surgical Services provider guidelines page at www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html.



Client Name
Medicaid I.D. Number

Hysterectomy Consent

Complete **only one** of the sections below.

I. Cases where a woman is capable of bearing children

PHYSICIAN'S STATEMENT

This hysterectomy is not being performed for the sole purpose of rendering the above named patient permanently incapable of reproducing. The patient and her representative, if any, were informed both verbally and in writing that the surgical procedure, hysterectomy, would render her permanently incapable of bearing children. I am recommending a hysterectomy for this patient for the following medical reasons:

Physician's Signature

Date

PATIENT'S OR REPRESENTATIVE'S STATEMENT

Prior to the surgical procedure, I received and understood both oral and written information explaining that after undergoing a hysterectomy I will be permanently incapable of bearing children.

Patient's or Representative's Signature

Date

In this circumstance only, a copy of this form must be given to the patient and one copy must be given to her representative if the patient is represented by another person.

II. Cases of previous sterility or life-threatening emergency

The patient's acknowledgment was not required because of the following circumstance (check applicable box):

The individual was sterile at the time of the hysterectomy. State the cause of the sterility:

The hysterectomy was performed under a life-threatening emergency situation in which I determined prior acknowledgment was not possible. Describe the nature of the emergency:

Physician's Signature

Date

III. Cases of retroactive Medicaid eligibility

(Complete section II for cases where the patient was previously sterile or the hysterectomy was performed under a life-threatening emergency.)

Before I performed the hysterectomy, I informed the above-named patient the hysterectomy would make her permanently incapable of bearing children.

Physician's Signature

Date



Client Name
Medicaid I.D. Number

Consentimiento para Histerectomía (Hysterectomy Cosent)

Llene **sólo una** de las siguientes secciones.

I. Casos en la mujer puede tener hijos

Esta histerectomía no se realiza con el sólo propósito de hacer que la paciente nombrada arriba quede permanentemente incapaz de reproducirse. La paciente y su representante, de haber alguno, fueron informados tanto verbalmente como por escrito que el procedimiento quirúrgico, histerectomía, la dejaría permanentemente incapaz de tener hijos. Recomiendo una histerectomía para esta paciente por las siguientes razones médicas:

Firma del médico

Fecha

DECLARACIÓN DE LA PACIENTE O DEL REPRESENTANTE

Antes del procedimiento quirúrgico, recibí y entendí información tanto oral como escrita que me explicó que después de someterme a una histerectomía quedaré permanentemente incapaz de tener hijos.

Firma del paciente o del representante

Fecha

Sólo en esta circunstancia, se debe dar una copia de este formulario a la paciente y se debe dar una copia a su representante si la paciente está representada por otra persona

II. Casos de esterilidad previa o emergencia en que pelagra la vida

El reconocimiento de la paciente no se requirió debido a la siguiente circunstancia (marque la casilla que corresponda):

La persona era estéril al momento de la histerectomía. Escriba las causas de la esterilidad:

La histerectomía se realizó durante una situación de emergencia en que peligraba la vida en la que determiné que no era posible el reconocimiento previo. Describa la naturaleza de la emergencia:

Firma del médico

Fecha

III. Casos de elegibilidad retroactiva de Medicaid

(Llene la sección II para los casos en que la paciente ya era estéril o la histerectomía se realizó durante una emergencia en que peligraba la vida.)

Antes de realizar la histerectomía, le informé a la paciente arriba nombrada que la histerectomía la dejaría permanentemente incapaz de tener hijos.

Firma del médico

Fecha

DMAP 742A and DMAP 742B- Consent to Sterilization forms

Use the DMAP 742A form for individuals who are 21 years of age or older, and the DMAP 742B form for individuals 15 to 20 years of age.

Mail a copy of the completed form to:

DMAP
PO Box 14958
Salem, OR 97309-4958

Make sure the client signs and dates the form 30 days prior to performing sterilization. DMAP will not pay for sterilization when the consent form has not been signed and dated by the client 30 days before the procedure is performed.

For more information

See OAR 410-130-0580 for more information about sterilization consent procedures and exceptions.

The **DMAP Hysterectomy and Sterilization Procedures Manual** contains more detailed information and tips not available in administrative rules.

This resource is available in the “Supplemental Information” section of the Medical-Surgical Services provider guidelines page at www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html.

How to complete the Consent to Sterilization form (DMAP 742A or DMAP 742B)

Top of Page 1	
1.	Enter the client's name, sex, and 8-digit Medicaid ID number where indicated.
Page 1: Patient's Statement	
2.	Enter the name of the doctor or clinic.
3.	Enter the name of the surgical procedure.
4.	Enter the client's birth date.
5.	Enter the client's name.
6.	Enter the name of the doctor performing the procedure.
7.	Enter the name of the procedure to be performed.
8.	The client must sign and date the consent.
9.	The client's race and ethnicity designation is optional.
Page 1: Interpreter's Statement – <i>Complete only if an interpreter is required</i>	
10.	Enter the name of the language used to explain the consent to the client.
11.	The interpreter must sign and date the consent.
Page 2: Statement of Person Obtaining Consent	
12.	Enter the client's name.
13.	Enter the name of the procedure to be performed.
14.	The person obtaining the consent must sign and date this statement. The date of signature must be on or after the client's signature date, but before the procedure date.
15.	Enter the name and full address of the physician or facility.
Page 2: Physician's Statement	
16.	Enter the client's name.
17.	Enter the date the procedure was performed.
18.	Enter the name of the procedure to be performed.
19.	<p>Alternative final paragraphs: Use paragraph 1 in most cases; use paragraph 2 in the case of premature delivery or emergency abdominal surgery where the procedure occurs less than 30 days after the client's signature date. Cross out the paragraph you do not use.</p> <p>When using paragraph 2, check the appropriate box.</p> <ul style="list-style-type: none"> ◆ If the first box is checked, enter the client's expected date of delivery. ◆ If the second box is checked, describe the circumstances requiring surgery.
20.	The performing physician must sign this consent. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

Consent to Sterilization

Client Name
Client sex
Female Male
Medicaid ID Number

Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

Patient's Statement

I have asked for and received information about sterilization from (doctor or clinic).

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds; such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done

until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits of medical services provided by Federally funded programs.

I am at least 21 years of age and was born on (month/day/year).

I, hereby consent of my own free will to be sterilized by (doctor) by a method called

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health (DH) and Oregon Health Authority (OHA) or Employees of programs or projects funded by the DH but only for determining if Federal laws were observed. I have received a copy of this form.

Signature

Date (month/day/year).

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

- Black (not of Hispanic origin) White (not of Hispanic origin)
Asian/Pacific Islander American Indian/Alaska Native
Hispanic

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent

Interpreter's Signature

form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Date (month/day/year).

Statement of Person Obtaining Consent

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the

Signature of Person Obtaining Consent _____
Date _____ (month/day/year).

individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Facility _____
Address _____

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized) on _____ (date of sterilization operation), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or

Physician's Signature _____

emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

- (1) At least 30 days have passed between date of the individual's signature on this consent form and the date the sterilization was performed.
- (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery: Individual's expected date of delivery _____.

Emergency abdominal surgery (describe circumstances): _____

Date _____ (month/day/year).



Consentimiento para esterilización

Client Name _____	
Client sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Medicaid ID Number _____

Aviso: Si en cualquier momento usted decide no ser esterilizado(a), su decisión no dará como resultado que le quiten o nieguen beneficios provenientes de programas o proyectos que reciben fondos federales.

Declaración del paciente

He solicitado y recibí información sobre esterilización de _____ (médico o clínica).

La primera vez que solicité la información me dijeron que la decisión de esterilizarme depende completamente de mí. Me dijeron que podía decidir no ser esterilizado(a) y que, si lo hacía, esta decisión no afectaría mi derecho a atención o tratamiento en el futuro. No perdería ninguna ayuda o beneficio de los programas que reciben fondos federales, como AFDC o Medicaid, que recibo actualmente o para los que podría ser elegible en el futuro.

Entiendo que la esterilización se debe considerar permanente y no reversible. Decidí que no quiero quedar embarazada, tener hijos ni engendrar hijos.

Me hablaron sobre los métodos anticonceptivos temporales disponibles que yo podría recibir y que me permitirían tener o engendrar hijos en el futuro. He rechazado estas alternativas y decidí ser esterilizado(a).

Entiendo que seré esterilizado(a) mediante una operación conocida como _____.

Me explicaron los malestares, riesgos y beneficios asociados con la operación. Todas mis preguntas recibieron respuestas satisfactorias.

Entiendo que la operación no se realizará hasta que hayan pasado por lo menos 30 días desde el momento en que yo firme este formulario. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no ser

esterilizado(a) no hará que se me niegue ningún beneficio de servicios médicos proveniente de programas financiados por el gobierno federal.

Tengo por lo menos 21 años de edad y nací el _____ (día/mes/año).

Yo, _____, por el presente doy mi consentimiento por mi propia voluntad para ser esterilizado(a) por _____ (médico) por el método denominado _____.

Mi consentimiento expira a los 180 días de la fecha de mi firma al pie de este formulario. También apruebo la divulgación de este formulario y demás registros médicos sobre la operación a: los Representantes del Departamento de Salud y Servicios Humanos o a los Empleados de programas o proyectos financiados por el Departamento, pero sólo para determinar si se cumplieron las leyes federales. He recibido una copia de este formulario.

Firma _____

Fecha _____ (mes/día/año)

Le pedimos que brinde la siguiente información, pero no tiene obligación de hacerlo: Raza y etnia (por favor marcar)

- Negro (no de origen hispano)
- Blanco (no de origen hispano)
- Asiático/Isleño del Pacífico
- Indoamericano/Nativo de Alaska
- Hispano

Declaración del intérprete

Si se ofrece un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que la persona que obtiene este consentimiento presentó oralmente a Firma del intérprete _____

la persona que será esterilizada. También le leí el formulario de consentimiento en idioma _____ y le expliqué su contenido. Según mi entender, él/ella entendió esta explicación.

Fecha _____ (día/mes/año).

Declaración de la persona que obtiene el consentimiento

Antes de que _____
(nombre de la persona) firmara el formulario de consentimiento, le expliqué la naturaleza de la operación de esterilización _____, el hecho de que es una intervención quirúrgica definitiva e irreversible y los malestares, riesgos y beneficios asociados a ella. Le expliqué a la persona que se va a esterilizar que también puede usar otros métodos anticonceptivos que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Informé a la persona que será

Firma de la persona que obtiene el consentimiento _____

Fecha _____ (mes/día/año)

esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ningún servicio ni beneficio de salud otorgado con fondos federales.

Según mi entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece mentalmente competente. Él/Ella solicitó ser esterilizado(a) voluntariamente y con conocimiento del tema, y parece entender la naturaleza y las consecuencias de esta intervención quirúrgica.

Institución _____

Dirección _____

Declaración del médico

Poco antes de realizar la operación de esterilización a _____ (nombre de la persona que será esterilizada) el día _____ (fecha de la operación de esterilización), le expliqué la naturaleza de la operación de esterilización _____ (especificar tipo de operación), el hecho de que es una cirugía definitiva e irreversible, y los malestares, riesgos y beneficios asociados a ella. Le expliqué a la persona que se va a esterilizar que también puede usar otros métodos anticonceptivos que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ningún servicio ni beneficio de salud otorgado con fondos federales.

Según mi entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece mentalmente competente. Él/Ella solicitó ser esterilizado(a) voluntariamente y con conocimiento del tema, y parece entender la naturaleza y consecuencias de la intervención quirúrgica.

(Instrucciones para el uso de párrafos finales alternativos: Usar el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, donde la esterilización se realiza antes de transcurridos los 30 días desde

Firma del médico _____

la fecha en que el paciente firma del formulario de consentimiento. En esos casos, se deberá usar el segundo párrafo. Tachar el párrafo no usado.)

- (1) Han transcurrido por lo menos 30 días entre la fecha en que el paciente firmó este formulario de consentimiento y la fecha en la que se realizó la esterilización.
- (2) Esta esterilización se realizó antes de transcurridos los 30 días, pero más de 72 horas después de la fecha en que el paciente firmó este formulario de consentimiento, debido a las siguientes circunstancias: (marcar lo que corresponda y dar la información solicitada)

Parto prematuro: Fecha prevista de parto de la paciente _____.

Cirugía abdominal de emergencia (describir las circunstancias): _____

Fecha _____ (mes/día/año).

Ages 15-20 Consent to Sterilization

Client Name
Client sex: Female Male
Medicaid ID Number

Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

Patient's Statement

I have asked for and received information about sterilization from (doctor or clinic).

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds; such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done

until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits of medical services provided by Federally funded programs.

I am between 15-20 years of age and was born on (month/day/year).

I, hereby consent of my own free will to be sterilized by (doctor) by a method called.

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health (DH) and Oregon Health Authority (OHA) or Employees of programs or projects funded by the DH but only for determining if Federal laws were observed. I have received a copy of this form.

Signature

Date (month/day/year).

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

- Black (not of Hispanic origin) White (not of Hispanic origin)
Asian/Pacific Islander American Indian/Alaska Native
Hispanic

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent
Interpreter's Signature

form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Date (month/day/year).

Statement of Person Obtaining Consent

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the

Signature of Person Obtaining Consent _____
Date _____ (month/day/year).

individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is between 15-20 years of age and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Facility _____
Address _____

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized) on _____ (date of sterilization operation), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is between 15-20 years of age and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or

Physician's Signature _____

emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

- (1) At least 30 days have passed between date of the individual's signature on this consent form and the date the sterilization was performed.
- (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery: Individual's expected date of delivery _____.

Emergency abdominal surgery (describe circumstances): _____

Date _____ (month/day/year).



15-20 años Consentimiento para esterilización

Client Name _____	
Client sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Medicaid ID Number _____

Aviso: Si en cualquier momento usted decide no ser esterilizado(a), su decisión no dará como resultado que le quiten o nieguen beneficios provenientes de programas o proyectos que reciben fondos federales.

Declaración del paciente

He solicitado y recibí información sobre esterilización de _____ (médico o clínica).

La primera vez que solicité la información me dijeron que la decisión de esterilizarme depende completamente de mí. Me dijeron que podía decidir no ser esterilizado(a) y que, si lo hacía, esta decisión no afectaría mi derecho a atención o tratamiento en el futuro. No perdería ninguna ayuda o beneficio de los programas que reciben fondos federales, como AFDC o Medicaid, que recibo actualmente o para los que podría ser elegible en el futuro.

Entiendo que la esterilización se debe considerar permanente y no reversible. Decidí que no quiero quedar embarazada, tener hijos ni engendrar hijos.

Me hablaron sobre los métodos anticonceptivos temporales disponibles que yo podría recibir y que me permitirían tener o engendrar hijos en el futuro. He rechazado estas alternativas y decidí ser esterilizado(a).

Entiendo que seré esterilizado(a) mediante una operación conocida como _____.

Me explicaron los malestares, riesgos y beneficios asociados con la operación. Todas mis preguntas recibieron respuestas satisfactorias.

Entiendo que la operación no se realizará hasta que hayan pasado por lo menos 30 días desde el momento en que yo firme este formulario.

Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no ser

esterilizado(a) no hará que se me niegue ningún beneficio de servicios médicos proveniente de programas financiados por el gobierno federal.

Tengo entre 15 y 20 años de edad y nací el ____ (día/mes/año).

Yo, _____, por el presente doy mi consentimiento por mi propia voluntad para ser esterilizado(a) por _____ (médico) por el método denominado _____.

Mi consentimiento expira a los 180 días de la fecha de mi firma al pie de este formulario. También apruebo la divulgación de este formulario y demás registros médicos sobre la operación a los Representantes del Departamento de Salud y Servicios Humanos o a los Empleados de programas o proyectos financiados por el Departamento, pero sólo para determinar si se cumplieron las leyes federales. Recibí una copia de este formulario.

Firma _____

Fecha _____ (mes/día/año).

Le pedimos que brinde la siguiente información, pero no tiene obligación de hacerlo: Raza y etnia (por favor marcar)

- | | |
|---|---|
| <input type="checkbox"/> Negro (no de origen hispano) | <input type="checkbox"/> Blanco (no de origen hispano) |
| <input type="checkbox"/> Asiático/Isleño del Pacífico | <input type="checkbox"/> Indoamericano/Nativo de Alaska |
| <input type="checkbox"/> Hispano | |

Declaración del intérprete

Si se ofrece un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que la persona que obtiene este consentimiento presentó oralmente a la persona que será esterilizada. También le leí el Firma del intérprete _____

formulario de consentimiento en idioma _____ y le expliqué su contenido. Según mi entender, él/ella entendió esta explicación.

Fecha _____ (mes/día/año).

Declaración de la persona que obtiene este consentimiento

Antes de que _____
(nombre de la persona) firmara el formulario de consentimiento, le expliqué la naturaleza de la operación de esterilización _____, el hecho de que es una intervención quirúrgica definitiva e irreversible y los malestares, riesgos y beneficios asociados a ella. Le expliqué que también puede usar otros métodos anticonceptivos que son temporales. Le expliqué que la esterilización es diferente porque es permanente.

Firma de la persona que obtiene el consentimiento _____

Fecha _____ (mes/día/año).

Informé a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ningún servicio ni beneficio de salud otorgado con fondos federales.

Según mi entender, la persona que será esterilizada tiene entre 15 y 20 años de edad y parece mentalmente competente. Él/Ella solicitó ser esterilizado(a) voluntariamente y con conocimiento del tema, y parece entender la naturaleza y las consecuencias de esta intervención quirúrgica.

Institución _____

Dirección _____

Declaración del médico

Poco antes de realizar la operación de esterilización a _____ (nombre de la persona que será esterilizada) el día _____ (fecha de la operación de esterilización), le expliqué la naturaleza de la operación de esterilización _____ (especificar tipo de operación), el hecho de que es una cirugía definitiva e irreversible, y los malestares, riesgos y beneficios asociados a ella. Le expliqué a la persona que se va a esterilizar que también puede usar otros métodos anticonceptivos que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ningún servicio ni beneficio de salud otorgado con fondos federales.

Según mi entender, la persona que será esterilizada tiene entre 15 y 20 años de edad y parece mentalmente competente. Él/Ella solicitó ser esterilizado(a) voluntariamente y con conocimiento del tema, y parece entender la naturaleza y consecuencias de la intervención quirúrgica.

(Instrucciones para el uso de párrafos finales alternativos: Usar el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía

Firma del médico _____

abdominal de emergencia, donde la esterilización se realiza antes de transcurridos los 30 días desde la fecha en que el paciente firma del formulario de consentimiento. En esos casos, se deberá usar el segundo párrafo. Tachar el párrafo no usado.)

- (1) Han transcurrido por lo menos 30 días entre la fecha en que el paciente firmó este formulario de consentimiento y la fecha en la que se realizó la esterilización.
- (2) Esta esterilización se realizó antes de transcurridos los 30 días, pero más de 72 horas después de la fecha en que el paciente firmó este formulario de consentimiento, debido a las siguientes circunstancias: (marcar lo que corresponda y dar la información solicitada)

Parto prematuro: Fecha prevista de parto de la paciente _____.

Cirugía abdominal de emergencia (describir las circunstancias): _____

Fecha _____ (mes/día/año).

DMAP 1036 - Individual Adjustment Request

Overpayments, underpayments and payments received after DMAP has paid a claim can be resolved through the adjustment process.

- Use the DMAP 1036 only to request adjustments for paid claims. If DMAP denied a claim that you think DMAP should have paid, you must correct and re-submit the claim for processing.
- To order the Individual Adjustment Request (DMAP 1036) form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE1036.pdf>.

Submit Individual Adjustment Request forms to:

DMAP
PO Box 14952
Salem, OR 97309

How to complete the Individual Adjustment Request (DMAP 1036)

Most required information is printed on the RA. You must have an RA for the claim to complete this form. You may submit documentation to support your request.

1.	Check the appropriate box if this request is an underpayment (DMAP paid too little) or an overpayment (DMAP paid too much).
4.	Enter the 13-digit Internal Control Number (ICN).
5.	Enter the date printed at the top of the RA.
6.	Enter the client's name. Use the same name as is shown on the Medical Care ID.
7.	Enter the client's recipient ID number.
8.	This space is for your provider name.
9.	Enter your 6- or 9-digit provider number.
10.	Enter your 10-digit National Provider Identifier (NPI), if available.
11.	This column contains possible areas you might want to correct. Only check the box you want to change. Use "Other" if none of the above boxes address your problems.
12.	Use the line number from the original claim you are adjusting.
13.	Enter the date you performed the service.
14.	Enter the incorrect information submitted on your original claim.
15.	Enter the corrected information.
16.	Give additional information or explain your request, if necessary.
17.	The signature of the provider or other authorized person must be in this space.

DHS 3970 - EDMS Coversheet

DMAP now requires this sheet as the cover for most mailed or faxed correspondence sent to DMAP for processing. To avoid delays in processing:

- **Do not submit paper claims or adjustment requests with this coversheet.** Mail them to the appropriate PO Box with any required documentation attached.
- **Make sure to submit each request you send to DMAP with its own EDMS Coversheet.** This allows DMAP to track each request as a separate document. You cannot send multiple requests under a single coversheet or combine document types.

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/DE3970.pdf>.

How to complete the DHS 3970

This sheet allows DMAP to scan your correspondence into the Electronic Document Management System (EDMS). To ensure appropriate processing of your PA request:

- **Always enter your National Provider Identifier and the client's ID number in the "Documentation Identification Numbers" section of this form.**
- **Always mark the "Prior Authorization" box in the "Document Type" section of this form for all PA-related submissions.** This is the only way the EDMS will recognize your PA request for automatic entry into the system.
- **For requests to revise existing PAs, enter the PA number in the "Documentation Identification Numbers" section of this form.** This is the only way EDMS will know to associate your revised PA request with an existing PA.

Requests for expedited PA

If you want to expedite your initial or revised PA request, mark the expedited timeframe you are requesting on the EDMS Coversheet and DHS 3971:

- "Urgent" processing (within 72 hours)
- "Immediate" processing (within 24 hours)

In addition to required information for the initial or revised request, submit written justification for expedited processing. A space to write this information is at the top of the EDMS Coversheet and DHS 3971.

Using the coversheet button in the Provider Web Portal

If you want to complete the coversheet while submitting your PA request on Provider Web Portal, make sure you click the "Submit" button before you complete the coversheet.

This enters your PA into the system and gives you the PA number you will need to enter in the "Documentation Identification Numbers" section of the coversheet.

DHS 3971 - Oregon DHS Prior Authorization Request

Use this form when submitting PA requests for professional services. Fax to one of the following numbers. Include required documentation and a completed EDMS Coversheet (see previous page).

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

To ensure appropriate processing of your PA request, make sure to complete the following required fields on new PA requests.

- Section I: Provider Number
- Section II: Type of PA Request
- Section III: Client ID
- Section IV: Revenue Center Code (if applicable)
- Section V: Procedure Code and Units (if applicable)
- Section VII: NDC (if applicable)
- Section IX: Date of Request, Service Begin and End Dates

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/DE3971.pdf>.



Oregon DHS Prior Authorization Request Form

For Internal Use Only: PA Number

I
Requesting Provider Name _____ Provider # _____
Contact Name _____ Contact Phone # _____
Contact Fax # _____ Processing Time Frame: Routine
 Urgent
 Immediate
Supporting Justification for Urgent/Immediate Processing Time Frame:

II
Type of PA Request
Assignment Code (check appropriate box)

<input type="checkbox"/> Audiology	<input type="checkbox"/> Home Health	<input type="checkbox"/> Physician
<input type="checkbox"/> Chemical Dependency Treatment Services	<input type="checkbox"/> Imaging	<input type="checkbox"/> SPD – CIIS (MFCU, CHN and Nursing)
<input type="checkbox"/> Dental Hospital Referral	<input type="checkbox"/> Inpatient Rehab	<input type="checkbox"/> Speech Services
<input type="checkbox"/> DME	<input type="checkbox"/> Medical Transportation	<input type="checkbox"/> Supplies
<input type="checkbox"/> Gambling Treatment Services	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Surgery
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Transplant
<input type="checkbox"/> Home EPIV	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Vision
<input type="checkbox"/> Other _____		

III
Client ID _____ DOB _____
Last Name _____ First Name, MI _____

IV
Service Information
Estimated length of treatment _____ Frequency _____
Length of time per session _____
Primary diagnosis _____ Primary ICD-9 diagnosis code _____
Other pertinent diagnosis _____
Facility: Name _____ Provider # _____
Revenue Center Codes _____

Please attach appropriate dental/medical/clinical justification for services requested (attach any plan of treatment, progress notes, invoices, etc. as needed).

V							
Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1						\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total Units					Total Cost		\$

VI **DENTAL**

Tooth Number _____ Quad _____

VII ***Fax all pharmacy PA requests to the Oregon Pharmacy Call Center at 888-346-0178.***

Pharmacy: Drug Name _____ Strength _____
 Quantity _____ NDC _____

Directions:

VIII

Performing Provider _____ Provider # _____

Contact Name _____ Contact Phone # _____

Contact Fax # _____ Billing Provider # _____

IX **Date Information**

Date of Request (MM/DD/CCYY) ____ / ____ / ____

Expected Service Begin Date ____ / ____ / ____

Expected Service End Date ____ / ____ / ____

Notes:

Attachments:

Document Control Number (DCN) _____

Report Type _____

Description of attachments:

DMAP 3978 - Pharmacy Prior Authorization Request

Prescribers should submit their PA requests for fee-for-service prescriptions and oral nutritional supplements with required documentation to:

Oregon Pharmacy Call Center

888-202-2126

Fax: 888-346-0178

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE3978.pdf>.

Information needed to request PA

Complete the form as follows. The Oregon Pharmacy Call Center may ask for some or all of the following information, depending upon the class of the drug requested:

DMAP 3978 section	Information needed
Section I:	Requesting provider name and National Provider Identifier.
Section II	Type of PA Request: Mark "Pharmacy."
Section III:	Client name and recipient ID number
Section IV:	Diagnosis code (ICD-9-CM)
Section V:	Drug name, strength, size and quantity of medication. ◆ Participating pharmacy: Include the dispensing pharmacy's name and phone number (if available).
Section VI:	Date of PA Request Begin and End Dates of Service
Section VII:	Procedure code(s) and cost information - Complete for EPIV and oral nutritional supplements only.
Section VIII	Patient questionnaire - Complete for oral nutritional supplements only.



Prior Authorization Request for Prescriptions & Oral Nutritional Supplements

To: Oregon Pharmacy Call Center
888-346-0178 (fax); 888-202-2126 (phone)

Confidentiality Notice:

The information contained in this Prior Authorization Request is confidential and legally privileged. It is intended only for use of the recipient(s) named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax document- except its direct delivery to the intended recipient - is strictly prohibited.

Complete all fields marked with an asterisk (*), if applicable.

I Requesting Provider

* Name * NPI
Contact Name Contact Phone
Contact Fax Processing Time Frame: Routine
Supporting Justification for Urgent/Immediate Processing: Urgent
Immediate

II PA Request - Assignment Code (check appropriate box)

* Pharmacy Home EPIV Other

III Client Information

* Client ID DOB / /
* Last Name * First Name, MI

IV Service Information

Estimated length of treatment Frequency
Primary diagnosis * Primary ICD-9 diagnosis code
Other pertinent diagnosis
(For prescriptions and oral nutritional supplements, list all applicable ICD-9 codes or contributing factors)

V Drug/Product Information

* Name * Strength
* Quantity * NDC

Participating Pharmacy:

Name Phone Number Date / /

VI Date Information

* Date of Request / /
* Expected Service Begin Date / /
* Expected Service End Date / /

VII Code and Cost Information – Required for EPIV and oral nutritional supplements

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1					0.00	0.00	0.00
2					0.00	0.00	0.00
3					0.00	0.00	0.00
4					0.00	0.00	0.00
5					0.00	0.00	0.00
			Total Units	0			\$0.00

VIII Patient Questionnaire – Complete for oral nutritional supplements only

Question	Yes	No
Is the patient fed via G-tube?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient currently on oral nutritional supplements? - If Yes, date product started: _____ - How is it supplied (e.g., self-pay, friends/family supply, etc)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have Failure to Thrive (FTT)?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a long history (more than one year) of malnutrition and cachexia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient reside in a: - Long-term care facility? - Chronic home care facility? - If Yes, list name of residence: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Does the patient have: - Increased metabolic need from severe trauma (e.g., severe burn, major bone fracture)? - Malabsorption difficulties (e.g., Crohn's Disease, cystic fibrosis, bowel resection/removal, Short Gut Syndrome, gastric bypass, renal dialysis, dysphagia, achalasia)? - A diagnosis that requires additional calories and/or protein intake (e.g., cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson's, cerebral palsy, Alzheimer's)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Date of last MD assessment for continued use of supplements: _____

Date of Registered Dietician assessment indicating adequate intake is not obtainable through regular or liquefied pureed foods: _____

- Serum Protein level: _____ Date taken: _____
- Albumin level: _____ Date taken: _____
- Current weight: _____ Normal weight: _____

Written Justification and Attachments:

Requesting Physician's signature: _____

Maternity Case Management forms

Providers must complete the following forms to meet minimum documentation requirements for Maternity Case Management Services. See OAR 410-130-0595 for more information on Maternity Case Management.

DMAP 2470 - Initial Assessment and Client Service Plan

DMAP 2471 - Training and Education Tracking

DMAP 2472 - Home / Environmental Assessment

DMAP 2473 - Five A's Intervention Record for Smoking Cessation

OREGON MATERNITY CASE MANAGEMENT INITIAL ASSESSMENT

Client Name	DOB	Age	S M D W
Prenatal Care Provider (If none, referral made <input type="checkbox"/>)	Referral Source:		EDC _____
Prenatal Care began at _____ weeks	_____ Gravida	_____ Term	_____ Preterm _____ SAB _____ TAB _____ Living

		<div style="display: flex; justify-content: space-between; font-size: small;"> Problem * No Problem </div> <div style="border: 1px solid black; border-radius: 10px; padding: 2px; margin: 5px auto; width: 80%;">*Requires documentation</div>			<div style="display: flex; justify-content: space-between; font-size: small;"> Problem * No Problem </div> <div style="border: 1px solid black; border-radius: 10px; padding: 2px; margin: 5px auto; width: 80%;">*Requires documentation</div>
		PHYSICAL/DENTAL/MENTAL			ENVIRONMENTAL
		Obstetric History & Experience			Housing & Living Situation
		Mental Illness			Guns (locked & unloaded)
		Physical Illness			Phone
		Dental Health			Smoke Alarm (installed & working)
		Special Needs			Exposure to Lead
					Exposure to Toxins
					Pets in Home
		PSYCHOSOCIAL/BEHAVIORAL			NUTRITION
		Substance Use: Self/Significant Others			✓ Diet
		Tobacco Exposure: Active/Passive			Pre-pregnant Weight
		STD/HIV Risk Assessment			Body Image
					Prenatal Vitamins/Folic Acid
		DEVELOPMENTAL/EDUCATIONAL			EMOTIONAL/RELATIONSHIPS
		Last Grade Completed			Domestic Abuse
		Literacy			History of Sexual Abuse
		Mental, emotional or physical condition affecting learning			Suicide Ideation/Attempt
		Communication/Special Needs			Depression/Anxiety
		TRANSPORTATION			Support System
		SELF-ASSESSED STRESS LEVEL			Self-Esteem
		<input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High			Father of Baby Involvement
		<input type="checkbox"/> Meets criteria for High Risk Case Management			
		<input type="checkbox"/> RELEASE OF INFORMATION/Date: _____			

Form Sent To	Referred To: _____
Completed By	NOTES
Agency	
Date	

**OREGON MATERNITY CASE MANAGEMENT
Client Service Plan**

Client Name	DOB	EDC
-------------	-----	-----

Client Strengths

Client Concerns

Case Manager Concerns

DATE	PROBLEM	CLIENT'S GOALS OR PLAN	Outcome		
			Met	Partially Met	Not Met

		PROGRESS TOWARDS GOALS/CASE MANAGER NOTES

Discharge Summary/Plan:

Signature	Printed Name	Agency	Date
-----------	--------------	--------	------

**OREGON MATERNITY CASE MANAGEMENT
TRAINING AND EDUCATION TRACKING**

Client Name				DOB	
MANDATORY EDUCATION/TRAINING TOPICS					
	Date	Initials		Date	Initials
1. Alcohol/Tobacco/Other drug exposure			5. Maternal oral health		
2. Breastfeeding promotion			6. Nutrition/Healthy weight/Physical activity		
3. Intimate Partner Violence (IPV)			7. Perinatal mood disorders		
4. Maternal/Fetal HIV (Human Immunodeficiency Virus) and Hepatitis B transmission			8. Prematurity and pre-term birth risks		
Other Topics: _____					
TOPICS NOT MANDATORY					
Date	Initials	PREGNANCY/CHILDBIRTH	Date	Initials	ENVIRONMENT
		Common discomforts/interventions			Asthma triggers
		Coping strategies			Drinking water
		Fetal growth/development			Home cleaning supplies
		Labor/birth process			Housing
		Pregnancy danger signs/symptoms			Lead exposure/screening
		Relationship changes			Non-fluoridated water community
		Safety in automobiles (proper use of seat belts and infant car seats)			Occupational exposures
		Stress reduction			Safety/sanitation
		Other emergencies			Tobacco smoke exposure
		HEALTH STATUS			Toxins/Teratogens
		Digestive tract changes			PARENTING
		Food availability			Bonding/attachment
		Food selection/preparation			Child nurturing/protection/safety
		Medications			Early childhood caries prevention
		Mercury consumption from eating fish			Immunizations/well child care
		Other existing health conditions during pregnancy			Infant care

**OREGON MATERNITY CASE MANAGEMENT
HOME/ENVIRONMENTAL ASSESSMENT**

Client Name

DOB

Street Address

Concern * No Concern		*Requires documentation	Concern * No Concern		*Requires documentation
HOUSING / LIVING SITUATION			FOOD PREPARATION FACILITIES		
		Adequacy / condition of shelter			Adequacy / condition
		Heating / cooling/ ventilation	SAFETY		
		Cleanliness			Guns/weapons (locked and unloaded)
		Running / potable water			Wood stove/fireplace
		Number of bedrooms / persons			Fire prevention (e.g. smoking habits)
		Phone service			Smoke alarm (installed & working)
		Sewage / garbage disposal			Exposure to lead (paint, pipes)
FOOD STORAGE FACILITIES					Exposure to toxins (asbestos, chemicals)
		Adequacy / condition			Pets in home (cats, birds, reptiles)

CLIENT CONCERNS

CASE MANAGER CONCERNS

RECOMMENDATIONS

Signature

Printed Name

Agency

Date

FOLLOW-UP

Signature

Printed Name

Agency

Date

**OREGON MATERNITY CASE MANAGEMENT
FIVE A's INTERVENTION RECORD (FAIR) FOR SMOKING CESSATION**

Client Name	DOB
Prenatal Care Provider:	Fax #

Use one column per visit.

	1	2	3	4	5
At each visit, enter DATE/INITIALS.					

1	ASK all clients about their smoking status. Complete all that apply for clients who currently smoke or who have smoked in the past 6 months. <i>If client is not currently smoking, go to section 5.</i>
----------	---

1. If client is NOT CURRENTLY SMOKING and quit LESS THAN 6 months ago, enter the most recent quit date (or approximate). Go to section 5.					
---	--	--	--	--	--

2. If client is currently smoking, enter the number of cigarettes smoked per day.					
---	--	--	--	--	--

2	ADVISE smoking client to quit. Check here to indicate that the client was advised.				
----------	---	--	--	--	--

3	ASSESS willingness to make a quit attempt within 30 days.
----------	--

1. If client is ready to try to quit, check here. Go to section 4.					
--	--	--	--	--	--

2. If client is not ready to try to quit, provide motivational counseling. Check here to indicate such counseling was provided. Go to section 5.					
--	--	--	--	--	--

4	ASSIST client with quitting. Check all that apply.
----------	---

1. Client received information and referrals.					
---	--	--	--	--	--

2. Client accepted referral to the Quit Line.					
---	--	--	--	--	--

3. Client did not accept referral to the Quit Line.					
---	--	--	--	--	--

5	ARRANGE follow-up. Check if next visit planned.				
----------	--	--	--	--	--

1. If follow-up plans were discussed, check here.					
---	--	--	--	--	--

2. If intervention record was faxed to prenatal care provider, check here.					
--	--	--	--	--	--

Initials	Signature	Printed Name	Agency
----------	-----------	--------------	--------

Initials	Signature	Printed Name	Agency
----------	-----------	--------------	--------

DMAP 9033 - Lead Risk Assessment Questionnaire

Providers must complete the following form for all children ages 12 to 72 months as part of the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program. For more information, instructions and tables relating to EPSDT, see OAR 410-130-0245.

Lead Risk Assessment Questionnaire

Primary Care Provider: Keep this questionnaire in client's records.

Child's Name (Last, First MI)		Client ID	
Child's Address			
City	County	State	ZIP
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone	
Parent/Guardian's Name			

Primary Care Provider:

- For children with any signs or symptoms of lead poisoning, including behavioral and developmental problems and ingestion of foreign body, blood lead testing should also be performed.
- For children without signs or symptoms of lead poisoning, review this questionnaire with the parent/guardian.

	Yes	No	Don't Know
1. Has your child lived in or regularly visited a home, child care or other building built before 1950?			
2. Has your child lived in or regularly visited a home, child care, or other building built before 1978 with recent or ongoing painting, repair or remodeling?			
3. Is your child enrolled in or attending a Head Start program?			
4. Does your child have a brother, sister, other relative, housemate or playmate with lead poisoning?			
5. Does your child spend time with anyone who has a job or hobby where they may work with lead? <i>Examples: painting, remodeling, auto radiators, batteries, auto repair, soldering, making sinkers, bullets, stained glass, pottery, going to shooting ranges, hunting or fishing.</i>			
6. Do you have pottery or ceramics made in other countries, or lead crystal or pewter that are used for cooking, storing or serving food or drink?			
7. Has your child ever taken any traditional home remedies or used imported cosmetics? <i>Examples: Azarcon, Alarcon, Greta, Rueda, Pay-loo-ah, or Kohl.</i>			
8. Has your child been adopted from, lived in or visited another country?			
9. Do you have concerns about your child's development or behavior?			

<p>These questions were reviewed with the parent/guardian. The parent/guardian:</p> <p style="text-align: center;"> Refused to answer questions <input type="checkbox"/> Yes <input type="checkbox"/> No Refused blood test for child <input type="checkbox"/> Yes <input type="checkbox"/> No </p>		
Provider/Authorized Representative	Signature	Date

DMAP Forms Request

Instructions:

1. Fill in the Provider information at right (type or print clearly).
2. Order only those forms listed in the chart below. CMS 1500 Billing Forms are NOT available through DAS printing or DMAP.
3. Fill in the number of packages column.
4. Fold page in thirds, seal with adhesive strip, affix postage. Mail to:
 DAS Distribution Center
 550 Airport Rd SE
 Salem OR 97310

Provider Name		
Street Address (NOT PO Box)		
City	State	ZIP
Area Code & Phone		

Forms available in packages of 50

CMS 1500 billing forms are available through business forms suppliers.

Form #	Title	Qty	Packages
DMAP 2420	DMAP Forms Request cards (5 max)		
DMAP 405T	Med. Transportation Order		
DMAP 406	Med. Transport. Eligibility Screening & Med. Transportation Order		
DMAP 505	Medicare/Medicaid Billing Inv. (cont.)		
DMAP 741	Hysterectomy Consent English Spanish		
DMAP 742A	Consent to Sterilization English Spanish		
DMAP 742B	Ages 15-20 Consent to Sterilization English Spanish		
DMAP 1036	Individual Adjustment Request		

The above forms and other DMAP forms are available on OHA Web site at
www.oregon.gov/OHA/healthplan

Appendix

Pharmaceutical references

Pharmacy rules and supplemental information are on the Web at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html. Referenced OARs are from the Pharmaceutical Services rulebook (OAR 410 Division 121) unless otherwise noted.

Drug Use Review (DUR)

See OAR 410-121-0100.

Prescription requirements (for fee-for-service clients only)

Follow criteria outlined in OAR 410-121-0145.

Practitioner-Managed Prescription Drug Plan (PMPDP)

The PMPDP ensures that fee-for-service OHP clients will have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price. Follow criteria outlined in OAR 410-121-0030.

Preferred Drug List

Part of the PMPDP, the Preferred Drug List (PDL) is a tool to identify the most cost-effective drugs for open-card OHP patients. New prescriptions for non-preferred physical health drugs require prior authorization.

For more information about the PDL, go to the OHP Web site at www.oregon.gov/OHA/healthplan/tools_prov/pdl.shtml.

Prior authorization - *See OAR 410-121-0060 for more information*

A prescriber electing to order a drug requiring PA may have any licensed medical personnel in their office call the Oregon Pharmacy Call Center (see page 2 for contact information and forms to use).

Pharmaceutical reimbursement

See OAR 410-121-0155. For physician-administered drugs, Clozapine therapy supervision and billing, see OAR 410-130-0180 (Medical-Surgical rulebook).

Medicaid Drug Rebate Program

See OAR 410-121-0157. This federal program requires drug manufacturers to enter into an agreement with CMS to provide rebates to DMAP on all their drug products. DMAP will only reimburse providers for drug products that are manufactured or labeled by companies who participate in the program.

For a list of participating drug manufacturers, see the CMS Web site at www.cms.hhs.gov/MedicaidDrugRebateProgram/02_StateReleases.asp.

Medication Therapy Management Service Claims (MTMS)

DMAP will reimburse pharmacies for Medication Therapy Management Services (MTMS) provided by pharmacists. Services must be provided based on referral from a physician, licensed provider, or a Prepaid Health Plan (PHP).

For documentation requirements, refer to Guideline Note 64 of the Prioritized List of Health Services. For specific information on when to bill for MTMS, refer to CPT coding guidelines.

Vaccines for Children program - *See OAR 410-146-0255(4) for more information*

The Vaccines for Children program (VFC) supplies federally purchased free vaccines for immunizing eligible children in public and private practices - at no cost to participating private health care providers. Patients through age 18 are eligible if they are:

- Enrolled in Medicaid or the Oregon Health Plan;
- Uninsured; or
- American Indian/Alaskan Native.

For more information, go to the VFC Web site at <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx>.

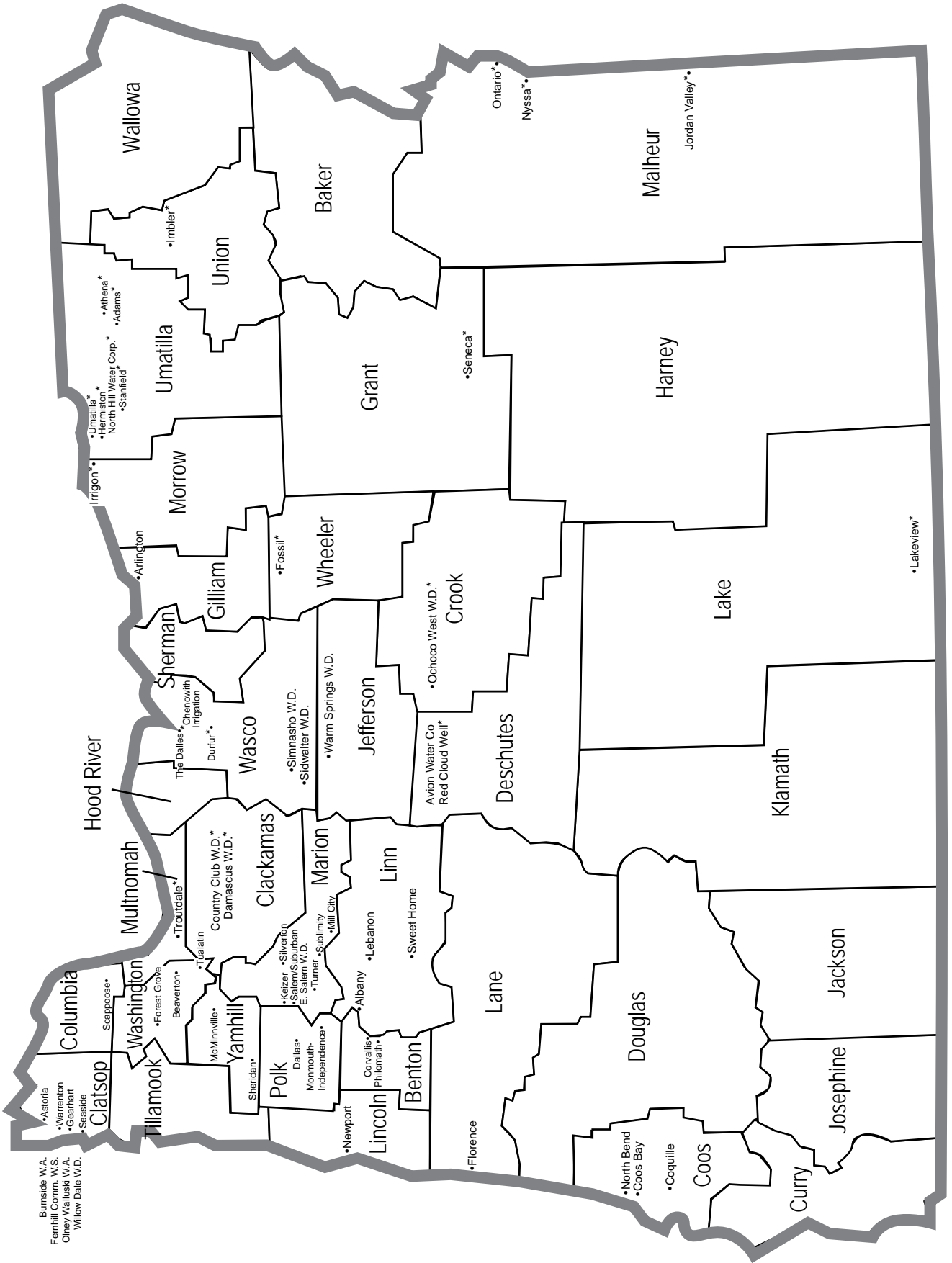
To enroll in the VFC program, call 971-673-0300 and request a “VFC Recruitment Packet.”

Oregon water systems with fluoride

The map on the next page shows communities and water districts with water supplies that have naturally occurring fluoride or adjusted fluoride.

Oregon water systems with fluoride

* Denotes systems with naturally occurring fluoride



Systems with naturally occurring fluoride

Over time or seasonally, these systems can show variations of up to 0.5 parts per million (ppm). To obtain the most current level, contact the water system directly.

Name	Phone	County
Country Club Water District	503-622-5374	Clackamas
Damascus Water District	503-658-5585	Clackamas
Ochoco West Water District	541-447-5612	Crook
Avion Water Co. Red Cloud Well	541-382-5342	Deschutes
Arlington	541-454-2743	Gilliam
Seneca	541-542-2161	Grant
Lakeview	541-947-2371	Lake
Jordan Valley	541-586-2460	Malheur
Nyssa	541-372-2264	Malheur
Ontario	541-889-8011	Malheur
Irrigon	541-922-3047	Morrow
Troutdale (1/3 of system)	503-661-5165	Multnomah
Adams	541-566-3841	Umatilla
Athena	541-566-3862	Umatilla
Hermiston	541-567-5221	Umatilla
North Hill Water Corporation	541-567-6764	Umatilla
Stanfield	541-449-3831	Umatilla
Umatilla	541-922-3226	Umatilla
Imbler, City of	541-531-6095	Union
Chenoweth Water People's Utility District	541-296-8027	Wasco
Dufur	541-467-2401	Wasco
Fossil	541-763-2698	Wheeler

Drinking Water Program, PO Box 14450, Portland OR 97214-0450; 971-673-0405

Recommended dietary fluoride supplementation schedule

Age	Less than 0.3 ppm F	0.3 - 0.6 ppm F	More than 0.6 ppm F
Birth – 6 mos.	0	0	0
6 mos. – 3 yrs.	0.25 mg/day	0	0
3 yrs. – 6 yrs.	0.50 mg/day	0.25 mg/day	0
6 yrs. up to at least 16 yrs.	1.00 mg/day	0.50 mg/day	0

American Academy of Pediatric Dentistry, *Special Issue: Reference Manual 1997-1998, Volume 19, Number 7.*