

**SOONERCARE PROVIDER APPLICATION
FOR AI/AN TRIBES**

- Application must be typed or printed in black ink. **All information must be completed or marked "N/A".**
- When completing this application, keep in mind the questions pertain to the organization named in the agreement.
- If you have any questions regarding this application, please contact Provider Enrollment at (800)522-0114, option 5 or locally at (405)522-6205, option 5.

OKLAHOMA MEDICAID INFORMATION	
SECTION I	<p>Are you currently or have you ever been enrolled in the Oklahoma Medicaid Program? <input type="checkbox"/> Yes, I am currently enrolled. <input type="checkbox"/> Yes, I was in the past. Go to Section II. <input type="checkbox"/> No. Go to Section II.</p> <p>Current Provider ID _____ (<i>Medicaid Legacy Number - OMB provider number</i>) If currently enrolled, please check one of the following:</p> <p><input type="checkbox"/> Change of ownership. Change Effective Date _____ Current Provider ID _____</p> <p><input type="checkbox"/> Additional service location. Effective Date _____ Current Provider ID(s) _____ <i>(If the first 9 digits are the same, only list once.)</i></p> <p><input type="checkbox"/> Other _____ Effective Date _____ Provider ID _____</p>
PROVIDER INFORMATION	
SECTION II	<p><input type="checkbox"/> IHS - Indian Health Service <input type="checkbox"/> Tribally Owned & Operated Facility</p> <hr/> <p>DBA (<i>Doing Business As</i>) Name _____ NPI (<i>National Provider Identifier</i>) _____</p> <p>First DOS (<i>Date of Service</i>) _____ Medicare Number _____ Medicare Certification Date _____</p> <p>License Number _____ Original Issue Date _____ DEA Number _____</p> <p>Are you enrolled in the Vaccine for Children (VFC) Program? <input type="checkbox"/> Yes <input type="checkbox"/> No VFC # _____</p>
ADDRESS INFORMATION	
SECTION III	<p>Service Location Address (<i>PO Box is not acceptable</i>) _____ Pay To (<i>If different from Mailing on Section 2.2 of the agreement</i>) _____</p> <p>City _____ State _____ Zip _____ 4 digit zip _____ City _____ State _____ Zip _____ 4 digit zip _____</p> <p>(_____) _____ (_____) _____ (_____) _____ (_____) _____</p> <p>Phone _____ Fax _____ Phone _____ Fax _____</p> <p>Contact Name _____ Contact Phone _____ Fax _____</p> <p>E-mail Address _____</p>
PAYMENT AND TAX REPORTING INFORMATION	
SECTION IV	<p>FEIN (<i>Federal Employer Identification Number</i>) _____ - _____</p> <p>IRS (<i>Internal Revenue Service</i>) Legal Name _____ <i>(Must match with IRS Form SS4 or IRS Letter 147C. A copy should be attached.)</i></p> <p>Print Authorized Representative Name _____ Authorized Representative Signature _____ Date _____</p>
Tribal Facilities Bill Back Information for services delivered to Non- AI/AN. Please provide the billing information requested below.	
SECTION V	<p>Billing Address _____ City _____ State _____ Zip _____</p> <p>Contact Person _____ Title _____ e-mail address _____</p> <p>Office Telephone _____ Office Fax Number _____</p> <p>Print Authorized Representative Name _____ Authorized Representative Signature _____ Date _____</p>

*** If you are an eligible primary care provider and choose to enroll as a group Choice and/or O-EPIC Provider, please complete the applicable attachment(s).**