HEALTH SYSTEMS DIVISION

Kate Brown, Governor

Oregon Health Authority

Health Systems Division
Program/Facility Information Request Form

Provider Agency Name _____

Program/Facility Name _____

Location Address _____

City _____ **State** ____ **Zip Code** (5 digits) _____

County _____ **Program/Facility Type** _____

Phone (ext.) _____ **MMIS#** (If applicable) _____

Program/Facility Name _____

Location Address _____

City _____ **State** ____ **Zip Code** (5 digits) _____

County _____ **Program/Facility Type** _____

Phone (ext.) _____ **MMIS#** (If applicable) _____

Program/Facility Name _____

Location Address _____

City _____ **State** ____ **Zip Code** (5 digits) _____

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Phone (ext.) _____ **MMIS#** (If applicable) _____

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Location Address _____

City _____ **State** ____ **Zip Code** (5 digits) _____

County _____ **Program/Facility Type** _____

Phone (ext.) _____ **MMIS#** (If applicable) _____

Program/Facility Name _____

Location Address _____

City _____ **State** ____ **Zip Code** (5 digits) _____

County _____ **Program/Facility Type** _____

Phone (ext.) _____ **MMIS#** (If applicable) _____

E-mail completed electronic copies of this form to BHA.DocumentSupport@state.or.us.
Mail printed copies to: Health Systems Division
Attn: Geri Mulholand
500 Summer Street N.E., E-86
Salem, OR 97301

(Please note that program/facility forms will not be accepted without a provider agency form or if they are incomplete.)