INSTRUCTIONS:

Please submit this completed application and required attachments in order to apply for initial credentialing or recredentialing with Molina Healthcare. During initial credentialing, credentialing must be completed prior to completion of a contract for any organization/facility not currently contracted with Molina Healthcare. Approval of your credentialing does not constitute finalization/approval of your contract and network participation.

If your organization has more than one location:

- Complete a separate application for each of your locations if each location has had a separate state, CMS or accreditation survey.
- Complete one application which will cover all your locations if:
  - Your organization has had one state, CMS and/or accreditation survey that covered all your locations on the same date(s), or
  - Your organization is not accredited and not required to be surveyed by any state or federal organization as part of your licensure, registration and/or certification process.
- **This application must be filled out completely with all sections answered:**
  - Do not use white-out on any part of the application.
  - If there is NOT a checkbox in the section header to indicate a why a section is not applicable, the section should be completed by all applicants.
- **The information listed below should accompany the completed application:**
  - ☐ Current organizational or facility licenses/certifications/registrations
  - ☐ A copy of the letter verifying approval of CMS participation (if applicable)
  - ☐ Current liability insurance face sheet
  - ☐ W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility
    (Only Page 1 of this form is needed: http://www.irs.gov/pub/irs-pdf/fw9.pdf)
- If your organization is not accredited by a body listed in Section 4 of this application and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results
- *Incomplete applications will be returned for completion prior to processing.*
- *Please return this application and all attachments to the location specified on your cover letter.*

1. ORGANIZATION INFORMATION *(Provide physical location information on page 4)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # (primary):	Organization Medicaid # (primary):
Organization TIN (primary):	Organization NPI (primary):
Credentialing Contact Street Address: _____ Address Line 2: _____ City: State: Zip:	**Billing Address** *(if different than Credentialing)* Street Address: _____ Address Line 2: _____ City: State: Zip:
Contact Name: _____ Email: _____ Phone: _____ Fax: _____	Contact Name: _____ Email: _____ Phone: _____ Fax: _____

2. CURRENT INSURANCE COVERAGE:

(Please attach a copy of your current facility professional/general liability insurance face-sheet)

☐ *Please check here if your facility is not required to carry liability insurance.*

Professional Liability Insurance Information *(if available)*		
Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:		Coverage amount aggregate:

General Liability Insurance Information *(if no professional liability available)*		
Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:		Coverage amount aggregate:

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed with Molina Healthcare. Complete a copy of sections 3-4 of this application for every location where information differs between locations

3. PHYSICAL LOCATION INFORMATION: *(Include any additional information relevant to this location on a separate sheet)*	
Location DBA (if different than the Organization DBA)	
Other DBAs Previously Used (if under same ownership)	
Is this location Medicare Certified? ☐ Yes ☐ No	Is this the primary address? ☐ Yes ☐ No
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location Street Address: _____ Address Line 2: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	State provider # *(if applicable, LTC, etc.):* Is this location handicap accessible? ☐ Yes ☐ No
Please list any languages spoken by office personnel:	
Practice Limitations (e.g., age, gender, etc.):	

3. PHYSICAL LOCATION INFORMATION:

(Include any additional information relevant to this location on a separate sheet)

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Please check here if this location is not required to be licensed, certified, or registered by a State agency.*

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

Specialty & Federal Taxonomy Code

Specialty & Federal Taxonomy Code

4. ACCREDITATION / CERTIFICATION *(check all that apply):*		
☐ *Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.*		
☐ *Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.*		
Accreditation Organization		**Date of Last Survey**
☐ (CMS)	Medicare Certification (attach most recent survey and acceptance letter)	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care	
☐ (ACHC)	Accreditation Commission for Health Care	
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
☐ (ABCOP)	American Board for Certification in Orthotics/Prosthetics	
☐ (ACR)	American College of Radiology	
☐ (ASHI)	American Society for Histocompatibility and Immunogenetics	
☐ (BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)	
☐ (CAP)	College of American Pathologists	
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities	
☐ (COLA)	Committee of Laboratory Accreditation	
☐ (CHAP)	Community Health Accreditation Program	
☐ (CT)	The Compliance Team	
☐ (COA)	Council on Accreditation	
☐ (DNV)	Det Norske Veritas	

4. ACCREDITATION / CERTIFICATION *(check all that apply):*		
Accreditation Organization		**Date of Last Survey**
☐ (HFAP)	Healthcare Facilities Accreditation Program - AOA	
☐ (HQAA)	Healthcare Quality Association on Accreditation	
☐ (IAC)	The Intersocietal Accreditation Commission	
☐ (NABP)	National Association of Boards of Pharmacy	
☐ (NBAOS)	National Board of Accreditation for Orthotics Suppliers	
☐ (NCQA)	National Commission for Quality Assurance	
☐ (TJC)	The Joint Commission	
☐ (URAC)	URAC, (aka, American Accreditation Healthcare Commission)	
☐ *(*CABC)*	**Commission for the Accreditation of Birth Centers*	
** Molina only recognizes accreditation by CMS 'Deemed' bodies except for The CABC for 'Birthing Centers' and PPFA for 'Planned Parenthood' facilities.*		

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant Molina Healthcare permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize Molina Healthcare to request, receive and inspect any and all records pertinent to consideration of this application.

As a Molina Healthcare facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply Molina Healthcare with any information and documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:

I hereby grant permission for Molina Healthcare to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support Molina Healthcare's quality improvement and utilization review programs.

ATTESTATION:

I certify the information on this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below. I attest that the organization on this application maintains liability insurance as outlined by state requirements.

I acknowledge that decision of participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with Molina Healthcare and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by Molina Healthcare. All services rendered to Molina members must be individually authorized until a written notice of participation and conditions of participation is issued by Molina Healthcare.

This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (https://exclusions.oig.hhs.gov/) and System for Award Management (https://www.sam.gov/SAM/) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Signature: _____

(Stamped signature is not acceptable)

Printed Name: _____ Date: _____

MolinaHealthcare, Inc.

OWNERSHIP AND CONTROL DISCLOSURE FORM

Completion and submission of this form is a condition of participation and full and accurate disclosure of ownership and financial interest is required.A failure to submit the requested information may result in a refusal by Plan/Network to enter into an agreement or contract with individual and/or entity or intermination of any existing agreements.

Please answer all questions as of the current date. If additional space is needed please use an attached sheet. Federal statutes and regulations clearly prohibit Plan/Network from paying for items or services furnished, ordered or prescribed by excluded persons. Plan/Network is required to search the exclusions database not only by the name of the entity seeking to participate in the program, but also by the name of any owner or managing employee.

Under 42 CFR 455: Identifying information must be supplied as described in the below sub-sections. For additional detail, please see the federal CFR database. A link to this specific section is supplied below (relevant portions are subsections 455. 100 through 455. 106): https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl

Complete this form for all locations contracted or being contracted with Molina Healthcare, Inc. (Molina) where Molina members will be seen. Only one form is needed if multiple locations are owned by the same parent company.

I. Identifying Information	
Owner Type (checkone) ☐ Organization Ownership - If checking this box, sections2-6 are required to be completed. ☐ Individual Ownership - Check this box if: If the practitioner named below is a sole proprietor or the practitioner. (ITEMS 2-6 ARE NOT APPLICABLE, PROCEED TO SIGN AND DATE AT THE BOTTOM OF THE FORM.) ☐ Federal/State Owned - Check this box if: the facility named below is entirely state or federally funded. (ITEMS 2-6 ARE NOT APPLICABLE, PROCEED TO SIGN AND DATE AT THE BOTTOM OF THE FORM.)	
INDIVIDUALNAME: SSN (if Individual Ownership):	
DOING BUSINESS AS:	ORGANIZATION NAME:
FEDERAL TAX ID:	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):

II. OwnershipandControlInformation

List each office and/or individual, organization, corporation or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary. If there are no individuals or entities with 5% or more ownership/control interest, complete for managing employees.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

List those persons named that are related to each other (spouse, parent, child or sibling). Attach additional pages if necessary.

NAME AND TITLE	RELATIONSHIP	DOB

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR no owner or managing employee has ownership or controlling interest of 5% or more in any other entity.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

III. SUBCON TRACTOR INFORMATION

List each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have controlling interest in any subcontract in which the disclosing entity has direct or indirect ownership of 5% or more.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

Please provide the ownership name and address of any subcontractor with whom you have had a business transaction totaling more than $25,000 during the most recent 12-month period.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

IV. CRIMINAL OFFENSES

List each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XVIII, XIX or XX since the inception of those programs. Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form,OR there are no owners or managing employees that have been convicted of a criminal offence.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

V. SUSPENSION OR DEBARMENT

Have you, or any of your employees, or any individuals who have ownership and/or controlling interest in the disclosing entity ever been placed on the Federal Office of Inspector General Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid or Title XXVIII, XIX or XX service programs. If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: https://exclusions.oig.hhs.gov/ and https://www.sam.gov/portal/SAM/#1

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have been suspended, excluded, and debarred from participation in Medicare, Medicaid or other service programs.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

VI. STATUS CHANGES

Is a change of ownership anticipated within the next year?	☐ Yes	☐ No
If yes, list date of change in operations.	☐ Yes	☐ No
Is the facility operated by a management company or leased in whole or by part of another organization?	☐ Yes	☐ No
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	☐ Yes	☐ No
If yes, when	☐ Yes	☐ No

Any designated representative may complete and sign this form on the organization's behalf.

Whoever knowingly and will fully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with Plan/Network. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

Printed (or typed) NAME and

Title of person completing this form: _____ Date: _____

Signature: _____

Completely fill in the form above in Adobe Acrobat or Adobe Reader, and then electronically sign by clicking in the box above. You cannot make changes to this form once it has been electronically signed and you cannot save a partially completed form. If you do not have Adobe Reader or Adobe Acrobat, print this form and fill it in by hand. Signature stamps not accepted.