MOLINA HEALTHCARE

ENROLLMENT APPLICATION REQUIRED DOCUMENTATION CHECKLIST

Please submit current copies of ALL of the documentation listed below. Any missing or inaccurate information will delay the enrollment process.

- ○ W-9 form
- ○ Disclosure and Ownership Form (Facility Credentialing ONLY)
- ○ NYS License
- ○ NYS MMID
- ○ DEA
- ○ Proof of Malpractice Insurance
- ○ Group Roster
- ○ Supervising/Collaboration physician form (midlevels only)

We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are not considered in-network.

1776 Eastchester Road | Bronx, NY 10461
Attn: Network Operations
P: 877-872-4716
F: 844-879-4509
E: MHNYNetworkOperations@molinahealthcare.com

MOLINA HEALTHCARE

APPLICATION FOR PROVIDER ENROLLMENT

To begin the enrollment process, please complete the information appropriate to your specialty. Complete and return with the items on the attached checklist. All information must match NPPES.

Please ensure that your CAQH information is completed and released to us with the most up-to-date information.

Today's Date:	**Requested Effective Date:**	**Group Name:**
Group TAX ID:	**Group NPI:**	**Provider Name:**
Individual NPI#:	**SSN#:**	**DOB:**
Gender: ☐ Male ☐ Female	**Provider License#/State:**	**DEA Certificate#:**
CAQH#: **MEDICAID #:**	**Accepting new patients?** ☐ YES ☐ NO **PCP?** ☐ YES ☐ NO **Panel?** ☐ OPEN ☐ CLOSE	**Language(s) other than English:**

Taxonomy Code (required). Circle One: MD ☐ DO ☐ PA ☐ NP ☐ Other: ☐ _____

Primary Specialty:	**Taxonomy Code:**
Second Specialty:	**Taxonomy Code:**
Third Specialty:	**Taxonomy Code:**

Please note: A correspondence street level address must be applied when a remittance address is a PO Box. Please use additional sheets when needed for multiple addresses.

Address A	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	☐ **Primary Office** ☐ **Additional Office** ☐ **Correspondence** ☐ **Remittance** ☐ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐

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Address B	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐
Address C	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐
Address D	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐

All members can make an appointment and be treated at ***Address*: *A* ☐ *B* ☐ *C* ☐ *D* ☐**	Hospitalist at ***Address*: *A* ☐ *B* ☐ *C* ☐ *D* ☐**

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OFFICE CONTACT INFORMATION

Please use this space for indicating the best points of contact for each category. All email communications will also be sent to the email listed under "General Molina Updates"

Best contact (Please list name or N/A)	Email	Phone Number
General Molina Updates		
Credentialing-		
Office Manager-		
Quality-		
Clinical-		
Pharmacy-		
Billing-		

Authorized person completing form:

Name:	Phone:	Email:

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Supervising/Collaboration Physician Form

Name of Midlevel:	
NP/PA:	
NPI:	
Name of Supervising/Collab Physician:	
NPI of Physician:	
Effective date:	

Authorized person completing form:

Name:	Phone:	Email:

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