PROVIDER INFORMATION FORM (PIF) CREDENTIALING ATTACHMENT CHECKLIST

All the following documentation is required in order to complete the credentialing of all practitioners

Please include the following documents with the completed Provider Information Form:

- ☐ Copy of Board Certification Certificate(s), (if applicable)
- ☐ Copy of Curriculum Vitae/Resume (Not accepted as a substitute for completion of application.)
- ☐ Copy of ECFMG (Foreign Medical Graduate) Certificate (if applicable)
- ☐ Copy of W-9 for verification of each tax identification number used
- ☐ Copy of certificates for conducting x-ray and/or laboratory services (if applicable)

PRACTITIONER INFORMATION FORM

CREDENTIALING APPLICATION MUST BE ATTACHED OR YOU MAY PROVIDE THE PRACTIONERS APPLICABLE CAQH #____________

Complete and mail or fax to Molina at address below.

Practitioner	**Last Name**	**First**	**Middle Initial**	**Title**

SS# ________________ Tax ID # ________________ Date of Birth ____________ Sex _____ M _____ F

DEA # ________________ Expiration ________________ License # ________________ Expiration ________________

NPI # ____ Practitioner effective date with group ________________

Primary Specialty ________________ Board Certified _____ Y _____ N Certification Expiration Date ____________

To be listed in Provider Directory PCP _______ Specialist _________ Hospitalist _______

Medical School/Graduation Year ____

Residency/Date Completed ____

Are you associated with a Group _____ Clinic _____ Facility _____ N/A _____ JACHO Accredited ____ Y ____ N

Group/Clinic/Facility Name ____

Are you associated with an IPA ____ PHO _____ N/A _____ Hospital Affiliation ________________

Do you speak other languages? _____ Y _____ N If yes, which Languages? ________________

Practice Name ________________________________ Office Manager ________________

Street ____

City ________________ State _______ Zip Code ____________ Email ________________

Phone Fax

Mailing/Credentialing Address (if different)
Street/PO Box ____

City ________________ State _______ Zip Code ____________ Email ________________

Phone Fax

Billing Address (if different)
Street/PO Box ____

City ________________ State _______ Zip Code ____________ Email ________________

Phone Fax

OWNERSHIP AND CONTROL DISCLOSURE – <u>PLEASE READ CAREFULLY</u> (If applicable, include the ownership and control disclosure information on a separate attachment and submit with this form. If not applicable, please indicate below)
Under 42 CFR 455.104 (a) (1), a provider or "disclosing entity" that is not subject to periodic survey under subsection 455.104 (b) (2) must disclose to the Medicaid agency prior to enrolling, the name and address of each person with an ownership of controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under subsection 455.104 (a) (2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, sibling. Moreover, under subsection 455.104 (a) (3), there must be disclosure of the name of any other disclosing entity in which a person with ownership or controlling interest in the disclosing entity has an ownership or controlling interest.

____________ No I do not have any Ownership and Control Disclosures ____________Yes, I have Ownership and Control Disclosures – See Attached

Excluded Individuals: Through signature below, I hereby certify that any employees providing healthcare services as part of this application, are screened with the applicable background check including, but is not limited to, verification against the List of Excluded Individuals/Entities and/or any applicable state, federal or any other governmental exclusion databases.

I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I further understand completion of this form does not guarantee participation with Molina Healthcare of New Mexico.

Signature ____________________ Print ____________________ Date ____________________