



Open Panel Form

Please open our member panels with Molina Healthcare for the following providers:

Provider First and Last Name	Specialty	Address	City, State Zip

Group Name	TIN	Address	City, State Zip

Please fax or mail the completed form to:

Mailing Address:

Molina Healthcare of Ohio, Inc.
Attn: Provider Services
P.O. Box 349020
Columbus, Ohio 43234-9020
Fax: 614-781-1537

Name of individual completing this form: _____

Signature of individual completing this form: _____

Phone Number: _____

Date: ___/___/___

If you have any questions or concerns, please visit our website at www.molinahealthcare.com or call the Provider Services Department at **1-800-642-4168**. A representative will be available to assist you from 8:00 a.m. – 5:00 p.m. Monday through Friday.