



Non-Par Provider Contract Request Form

If you are not currently a contracted provider with Molina Healthcare of Ohio, Inc. and are interested in joining our network of quality healthcare providers, please print and complete this form and return via fax to the attention of Provider Contracts Fax # **614-781-1410**.

Provider Name: _____ Provider Type/Specialty: _____

Medicaid ID Number: _____

Practice Name: _____

(If your practice is a group practice, please provide the names and specialties of all practitioners in the group. You may attach a separate sheet if necessary.)

Mailing Address: _____

Primary Office Location: (if different from mailing address) _____

County: _____ Person Completing This Form: _____

Phone #: _____ Provider TIN: _____

E-Mail Address: _____

Are all practitioners employed physicians of the group? **Yes** or **No**

If **NO**: Please be advised that separate Provider Services Agreements will need to be completed and signed by each practitioner in the group. Further information will be provided via US Mail.

Any additional information you would like to include relative to your practice: _____

If your request is approved, a contract package will be mailed within seven to ten business days.

If you have any questions regarding completion of this form contact Provider Contracts at 1-800-642-4168, Option 1.

***Please note that completion of the above information is not confirmation of your participation status with Molina Healthcare of Ohio, Inc. Final contractual status is based upon your ability to meet credentialing standards and any additional contractual obligations.