



# Contract Request Form (CRF)

(please print legibly)

**Note to Provider:** In an effort to generate the proper contract and credentialing packet, please complete this contract request form and fax back to: 877-319-6851  
 Attn: Contracting Team or email form to: mhtcontracting@molinahealthcare.com.

Requestor Name: \_\_\_\_\_ Email: \_\_\_\_\_

\*Provider Name: \_\_\_\_\_ \*Group Name: \_\_\_\_\_

\*Specialty: \_\_\_\_\_ \*Tax ID: \_\_\_\_\_

\*\*Physical Address: \_\_\_\_\_ \*Mailing Address: \_\_\_\_\_  
 (\*\*Note: Physical Address where members are to be seen)

City, State, Zip: \_\_\_\_\_ \*City, State, Zip: \_\_\_\_\_

\*Office Phone: \_\_\_\_\_ \* Group Phone: \_\_\_\_\_

\*Office Fax: \_\_\_\_\_ \*Group Fax: \_\_\_\_\_

\*Ind TPI: \_\_\_\_\_ \*Group TPI: \_\_\_\_\_  
 (if TPI number is not attested- we are unable to contract for Medicaid) (if TPI number is not attested - we are unable to contract for Medicaid)

\*Ind NPI: \_\_\_\_\_ \*Group NPI: \_\_\_\_\_  
 (if NPI number is not attested- we are unable to contract for Medicaid) (if no valid NPI number - we are unable to contract for Medicaid)

\*Ind Medicare: \_\_\_\_\_ \*Group Medicare: \_\_\_\_\_  
 (if no valid Medicare number - we are unable to contract for Medicare) (if no valid Medicare number - we are unable to contract for Medicare)

STAR  CHIP  CHIP Perinate  STAR+PLUS  Medicare Options  Medicare Options +

Mail contract packet to (if different from above): \_\_\_\_\_

Date requested: \_\_\_\_\_ (please allow 7-10 business days for packet to be mailed out)

For Office Use Only	
Rep Name:	Rep Comments:
THSteps TPI:	Date Mailed out:
Grp. THSteps:	Notes:
Current Status:	
<b>Cactus</b> Credentialed: Y N Delegated: Y N	
<b>QNXT</b> Loaded: Y N PAR: Y N	
<b>MPF</b> Verified: Y N Specialty: _____	
<b>PC Tracker</b> Loaded: Y N	
<b>Packet Type</b> PSA HDO (circle one)	
Verified by:	Date: