Non-Par Provider Contract Request Form

If you are not currently a contracted provider with Molina Healthcare of Ohio and are interested in joining our network of quality health care providers, please email the completed form to MHONon-ParContractRequests@MolinaHealthcare.com or fax to the attention of Provider Contracts at **(866) 384-1226.**

If you are joining a contracted group, please do not complete or submit this form. On the Molina Healthcare website, look to the "Contracted Providers Making Changes" section for the appropriate forms and instructions.

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: _____

Email 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 mail.

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

_____

_____

_____

If your request is approved, you will be contacted by a contract manager within 30 days.

If you have any questions regarding completion of this form, contact Provider Contracts at (855) 322-4079, Option 1.

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

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