MOLINA® HEALTHCARE

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: Dallas Service Area: 972-756-9275, Houston Service Area: 281-599-8916, Bexar Service Area: 877-900-3072 Attn: Contracting Team or email form to: texasexpansioncontracting@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)

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: **Cactus** Credentialed: Y N Delegated: Y N **QNXT** Loaded: Y N PAR: Y N **MPF** Verified: Y Specialty:_____ **PC Tracker** Loaded: Y N **Packet Type** PSA HDO (circle one)	
Verified by:	Date:

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