Molina Healthcare, INC
Non-Clinical Provider Form

INSTRUCTIONS:

Please submit this completed non-clinical provider form and the required attachments. Incomplete forms will be returned for completion prior to processing.

The information listed below should accompany the completed form:

- ✓ *A copy of the letter verifying approval of Medicaid participation*
- ✓ *A copy of your certificate/registration to practice in your state*
- ✓ *A copy of your professional liability insurance certificate*

1. PROVIDER INFORMATION			
Individual Provider Name (last, first, middle initial)			
Gender		**Date of Birth**	
Social Security Number		**Individual Provider NPI**	
Medicaid Number		**Medicare Number (if applicable)**	
Individual Provider Specialty		**Individual Provider Taxonomy Code**	
Languages other than English		**Do you Provide Tele-Health Services**	
CAQH #		**Accepting new patients?**	
(If your CAQH application is current and Molina is authorized section 2 of this form not required)			
Group Name (as listed on line one of W9)			
Tax ID			
Group NPI (associated with the tax ID)			
Primary Location Address			
Address Line 2			
City, State, ZIP, County			
Primary location phone		**Primary location fax**	
Credentialing Contact Name		**Contact E-mail**	
Contact Phone		**Contact Fax**	
Liability Insurance Carrier			
Policy coverage dates	**Start date:**	**Expiration date:**	

Coverage amounts (per claim & aggregate amounts)	

2. MOLINA HEALTHCARE ATTESTATION QUESTIONS

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Since your last (re)appointment/(re)credentialing, have you been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national, or international regulatory agency or any public program	YES ☐	NO ☐
	d.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan, or other entity	YES ☐	NO ☐
	e.	Academic Appointment	YES ☐	NO ☐
2.	Since your last (re)appointment/(re)credentialing, have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association, or education/training institution?		YES ☐	NO ☐
3.	Since your last (re)appointment/(re)credentialing, have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO ☐
4.	Since your last (re)appointment/(re)credentialing, have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO ☐
B.	**CRIMINAL HISTORY**			
1.	Since your last (re)appointment/(re)credentialing, have you been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO ☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b.	Are you currently under governmental investigation?	YES ☐	NO ☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO ☐
2.	Since your last (re)appointment/(re)credentialing have you had any physical, mental health, or substance use condition that impairs, or could impair, your ability to practice your profession in a competent, ethical, and professional manner? If the answer to this question is yes, please complete Section 3 below.		YES ☐	NO ☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO ☐

3. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A copy, or electronic PDF with signature authentication, has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Review dates and initials: