MHIA Provider Contract Request Form

Thank you for your interest in becoming a Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to IAProviderContracts@MolinaHealthcare.com or fax to (833) 671-3988.

PLEASE SELECT PROVIDER TYPE					
☐ Individual	☐ Medical Group	☐ ASC	☐ Pharmacy	☐ FQHC	☐ RHC
☐ Behavioral Health	☐ Home Health	☐ DME	☐ Other		

LINE OF BUSINESS			
☐ Medicaid / CHIP	☐ Medicare Advantage	☐ Medicare - Medicaid	☐ Marketplace

CONTACT INFORMATION	
Requestor Name: _____	Requestor Phone: _____
Requestor Email: _____	Requestor Fax: _____

PROVIDER INFORMATION	
Legal Entity Name: _____	
Business/Service Address: _____ *(If additional locations please attach roster)*	Mailing address: _____ *(Contract will be emailed)*
City, State, Zip: _____	City, State, and Zip: _____
Office Phone: _____	Contact Phone: _____
Office Fax: _____	Contact Fax: _____
Office Email: _____	Contact Email: _____

PROVIDER IDENTIFICATION	
Group Specialty: _____	Tax ID (TIN): _____
Group Billing NPI(s): _____ ** List all Group NPI(s) applicable to the corresponding Tax ID*	
Medicare ID: _____	