



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.

If you are adding providers to a participating group or PHO/PO, please submit a Provider Information Update Form to IAProviderRelations@MolinaHealthcare.com.

PLEASE SELECT PROVIDER TYPE					
<input type="checkbox"/> Individual	<input type="checkbox"/> Medical Group	<input type="checkbox"/> ASC	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> FQHC	<input type="checkbox"/> RHC
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Home Health	<input type="checkbox"/> DME	<input type="checkbox"/> Other		

LINE OF BUSINESS			
<input type="checkbox"/> Medicaid / CHIP	<input type="checkbox"/> Medicare Advantage	<input type="checkbox"/> Medicare - Medicaid	<input type="checkbox"/> Marketplace

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

PROVIDER INFORMATION	
Legal Entity Name: _____	
Business/Service Address: _____ <i>(If additional locations please attach roster)</i>	Mailing address: _____ <i>(Contract will be emailed)</i>
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): _____ <i>*List all Group NPI(s) applicable to the corresponding Tax ID</i>	
**Iowa Medicaid ID Number: _____ <i>(A Medicaid ID is required. If you do not have a group/individual Medicaid ID issued from the Iowa Department of Health and Human Services, we will not be able to proceed with a group/individual agreement.)</i>	
Hospital Affiliation(s): _____	