## ATTACHMENT C PROVIDER ROSTER

				orm: 1. Practic 3. Provider De		formation 2.	Practice Nam	ıe,	
Co	ntract Entit	у Туре	Solo Practic	e 🗌 Grou	p Practice	IPA	FQH	IC/RHC	
Pra	actice Crea	dentialing co	ntact person	•					
Na	me:				Title:				
Ph	one:				Email:				
1									
	Group Name	e			Group NPI Group NPI		-	Group TIN	
	Group Name	e					Group TIN		
(	Group Name	e			Group NPI		Group TIN	Group TIN	
1.	Practice N		tory) - Treuse	list 'Same' if the		uding Bldg, S			
	City, State, Zip			County					
	Practice Phone			Practice Fax					
	Hours of (	Operation: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
	From – To								
2.									
2.	Practice N	lame			Address incl	uding Bldg, S	uite #		
	City, State, Zip Practice Phone			County					
				Practice Fax					
	Hours of C	Operation: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
	From – To								

Practice Name				Address including Bldg, Suite #				
City, State	e, Zip			County				
Practice F	Phone			Practice Fax				
Hours of (	Deration: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
From – To								

## In Order for Providers to be Affiliated with Practice, these items must be included: o CAQH ID - current Attestation, current practice listed, authorize Molina access o Must have active SCDHHS Medicaid ID o An incomplete package will delay or term the credentialing process If the PCP box is checked, Provider will be credentialed, listed in Molina Directory and assigned members.

l <u>.</u> Last Name	First Name	Degree	e CAQH ID and DOB (mm/dd/yyyy
Primary Specialty	Individual NPI	Ν	Medicaid ID #
Provider Practice Locations (Check	all that apply): 1 2	3 N	Medicare ID #
Do you intend to serve as a primary	care provider? Y	I E	Effective Date:
Do you intend to serve as a speciali	st? Y N		
Do you intend to show, and be sear	chable in Molina's online dire	ctory fo	r members? $\Box Y \Box N$
Do you solely see members in the in	npatient setting, i.e., do NOT	take app	pointments in office? $\Box Y \Box N$
Accepts New Patients? Y	N Current Molina Member	s?	Y 🗌 N
Other Member Enrollment Limitati	ons?		
Supervising MD (for Mid-level) Na	me:		
Supervising NPI:			

2.			
Last Name	First Name	Degree CAQH ID and D	OOB (mm/dd/yyyy
Primary Specialty	Individual NPI	Medicaid ID #	
Provider Practice Locations	(Check all that apply): 1	2 3 Medicare ID #	
Do you intend to serve as a	primary care provider? 🗌 Y	N Effective Date:	
Do you intend to serve as a	specialist? Y N		
	be searchable in Molina's onlin	e directory for members?	
Do you solely see members	in the inpatient setting, i.e., do	NOT take appointments in office?	
Accepts New Patients?	Y N Current Molina Me	mbers? 🗌 Y 🗌 N	
Other Member Enrollment	Limitations?		
Supervising MD (for Mid-le	evel) Name:		
Supervising NPI:			
3. Last Name	First Name	Degree CAQH ID and D	OOB (mm/dd/yyyy
Primary Specialty	Individual NPI	Medicaid ID #	
Provider Practice Locations	(Check all that apply): 1	2 3 Medicare ID #	
•	primary care provider? 🗌 Y	N Effective Date:	
Do you intend to serve as a	specialist? Y N		
Do you intend to show, and	be searchable in Molina's onlin	e directory for members?	Y N
Do you solely see members	in the inpatient setting, i.e., do	NOT take appointments in office?	Y 🗌 Y 🗌 N
Accepts New Patients?	Y N Current Molina Me	mbers? 🗌 Y 🗌 N	
Other Member Enrollment	Limitations?		
Supervising MD (for Mid-le	evel) Name:		
Supervising NPI:			

4.			
Last Name	First Name	Degree CAQH ID and DOB (mm/dd	/уууу
Primary Specialty	Individual NPI	Medicaid ID #	
Provider Practice Locations	(Check all that apply): 1	2 3 Medicare ID #	
Do you intend to serve as a	primary care provider?	N Effective Date:	
Do you intend to serve as a	specialist? Y N		
Do you intend to show, and	be searchable in Molina's online	e directory for members? $\Box Y$	N
Do you solely see members	in the inpatient setting, i.e., do ]	NOT take appointments in office? $\Box$ Y	Ν
Accepts New Patients?	Y 🗌 N Current Molina Me	embers? Y N	
Other Member Enrollment	Limitations?		
Supervising MD (for Mid-le	evel) Name:		
Supervising NPI:			
5 Last Name	First Name	Degree CAQH ID and DOB (mm/dd	/уууу
Primary Specialty	Individual NPI	Medicaid ID #	
Provider Practice Locations	(Check all that apply): 1	2 3 Medicare ID #	
Do you intend to serve as a	primary care provider? 🗌 Y 🛛	N Effective Date:	
Do you intend to serve as a	specialist? Y N		
Do you intend to show, and	be searchable in Molina's online	e directory for members?	]Ν
Do you solely see members	in the inpatient setting, i.e., do l	NOT take appointments in office? $\Box$ Y	N
Accepts New Patients?	Y 🗌 N Current Molina Me	embers? Y N	
Other Member Enrollment	Limitations?		
Supervising MD (for Mid-le	evel) Name:		
Supervising NPI:			

Degree	CAQH ID and DOB (mm/dd/yyyy
Me	edicaid ID #
3 Me	edicare ID #
Ef	fective Date:
ctory for a	members? $\Box Y \Box N$
take appo	intments in office? $\Box Y \Box N$
s? 🗌 Y	□ N
1	3  Me Effectory for the second