Molina Healthcare, Inc.
Health Delivery Organization (HDO) Form

INSTRUCTIONS:

Please submit this completed form and the required attachments. Incomplete forms will be returned for completion prior to processing. Please return this form and all attachments to the location specified on your cover letter.

Please complete an application for each unique TIN/NPI combination.

The information listed below should accompany the completed form:

- ✓ *Copies of current organizational or facility licenses/certifications/registrations*
- ✓ *A copy of your current (not expired) professional liability insurance face sheet*
- ✓ *A copy of the letter verifying approval of CMS participation (if applicable)*
- ✓ *If your organization is not accredited by a body listed in Section 4 of this form and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results.*
- ✓ *W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility (Only Page 1 of this form is needed: http://www.irs.gov/pub/irs-pdf/fw9.pdf)*

1. ORGANIZATION INFORMATION: *(Provide physical location information on the following page)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (will be used in the directory) (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # *(primary)*:	Organization Medicaid # *(primary)*:
Organization TIN *(primary)*:	Organization NPI *(primary)*:
Credentialing Contact Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____	**Billing Address** *(if different than Credentialing)* Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____

2. CURRENT PROFESSIONAL LIABILTY INSURANCE:	
☐ Please check here if your facility is not required to carry **professional** liability insurance.	
Current Carrier Name:	Policy Number:
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

(Include any additional information relevant to this location on a separate sheet)

Location DBA
(if different than the Organization DBA)

Other DBAs Previously Used
(if under same ownership)

Is this location Medicare Certified? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:

Physical Practice Location
Street Address**:**
Address Line 2**:** _____
City:_____ State:_____ Zip:_____
Phone:_____ Fax: _____

State provider # *(if applicable, LTC, etc.)*: _____
Is this location handicap accessible? ☐ **Yes** ☐ **No**

Please list any languages spoken by office personnel:

Practice Limitations (e.g., age, gender, etc.):

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Please check here if this location is not required to be licensed, certified, or registered by a State agency.*

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

Specialty & Federal Taxonomy Code	Specialty & Federal Taxonomy Code

4. ACCREDITATION / CERTIFICATION *(check all that apply)*:

☐ *Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.*

☐ *Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.*

Accreditation Organization		Date of Last Survey
☐ (CMS)	Medicare Certification *(attach most recent survey and acceptance letter)*	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care	
☐ (ACHC)	Accreditation Commission for Health Care	
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
☐ (AADE)	American Association of Diabetes Educators	
☐ (AAHHS)	Accreditation Association for Hospitals & Health Systems (AOA)	
☐ (ACR)	American College of Radiologists	
☐ (CABC)	Commission for the Accreditation of Birth Centers	
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities	
☐ (CCAC)	Continuing Care Accreditation Co	
☐ (CLIA)	Clinical Laboratory Improvement Amendments	
☐ (COLA)	Committee of Laboratory Accreditation	
☐ (CHAP)	Community Health Accreditation Program	
☐ (COA)	Council on Accreditation	
☐ (DNV)	Det Norske Veritas – National Integrated Accreditation for Healthcare Organizations	
☐ (IAC)	The Intersocietal Accreditation Commission	
☐ (IHS)	Indian Health Services	
☐ (OSHA)	Occupational Safety and Health Administration	
☐ (SAMHSA)	Substance Abuse and Mental Health Services Administration	
☐ (TJC)	The Joint Commission	