MOLINA HEALTHCARE | Molina Complete Care

MOLINA PROVIDER INFORMATION FORM

CHECK THE APPROPRIATE PROVIDER TYPE: ☐ Individual ☐ Group*

*Please complete one form for the group and then photocopy and complete supplemental versions of this form for each group member. Only complete the ***Practitioner Data*** sections for each supplemental version.

Practitioner Data - General Information

Provider First Name:	MI:	Last Name:	Suffix:
Degree (check one): ☐ MD ☐ DO ☐ DMD ☐ DPM ☐ CRNA ☐ NP ☐ CNM ☐ Other: _____			
SSN:	NPI:	DOB:	
CAQH #:	Medicare ONLY provider: ☐ YES ☐ NO		
Do you practice exclusively within the inpatient setting?* (E.g. Pathologists, Anesthesiologists, ER Physicians, Nurse Practitioner, Radiologists, Physician Assistant, etc.) ☐ YES ☐ NO			
Indicate the locations where the practitioner provides services: ☐ Primary ☐ #2 ☐ #3 ☐ #4 ☐ #5 ☐ #6 ☐ #7 ☐ #8 ☐ #9			

Main Site Practice Information

Primary Service Location Address (include ZIP + 4):	
Hospital Based: ☐ YES ☐ NO	Panel Status: ☐ Accepting New Patients ☐ Existing Patients Only ☐ Nursing Home Setting Only
Group Name:	
DBA, if applicable	
Main Site Phone # :	Group NPI:
Office Hours:	Practice Website:

Mailing Address

Mailing Address (if different from primary practice address):
Admin Phone:
Primary Email:

Pay To Information

Pay To:	TIN:
Pay To Address:	

Practitioner Data - Other Languages Spoken (*Please check all that apply*)

☐ Spanish	☐ German	☐ French	☐ Vietnamese	☐ Korean	☐ Navajo	☐ Tagalog
☐ Portuguese	☐ Italian	☐ Arabic	☐ Dakota	☐ Polish	☐ Other:	

Provider Designation

Please select the Provider Designation/Type(s). Please check all that apply.

Type	Description	Type	Description
☐ 01	Primary Care Provider (PCP)	☐ 16	Outpatient Rehabilitation (☐PT ☐OT ☐ST)
☐ 02	Pediatrician	☐ 17	Durable Medical Equipment (DME) and Supplies
☐ 03	Specialist (list specialty):	☐ 18	Radiology
☐ 04	Health Department	☐ 19	Home Health
☐ 05	Hospice	☐ 20	Laboratory
☐ 06	Long Term Services & Supports (LTSS)	☐ 21	Pharmacy
☐ 07	Outpatient Mental Health – Traditional Services	☐ 22	Vision
☐ 08	Addiction, Recovery, & Treatment Services (ARTS)	☐ 23	Transportation (☐Emergency ☐ Non-Emergency)
☐ 09	Community MH Rehabilitative Services (CMHRS)	☐ 24	Other (please describe):
☐ 10	Hospital - Psychiatric	☐ 25	OB/GYN
☐ 11	Hospital – General (☐ Pediatric)	☐ 26	Federally Qualified Health Center (FQHC)
☐ 12	Hospital – Physical Rehabilitation	☐ 27	Community Services Board (CSB)
☐ 13	Urgent Care	☐ 28	Rural Health Clinic (RHC)
☐ 14	Nursing Facility (☐Intermediate ☐ Skilled)	☐ EI	Early Intervention

Email MCCVA-Provider@molinahealthcare.com or fax to 888-656-5098

Long-Term Services & Supports (LTSS) Procedure Codes

Please select the service codes you provide. Please check all that apply.

Proc Code	Description	Proc Code	Description	Proc Code	Description
☐ S5102	Adult Day Health Care	☐ S5160	PERS Installation	☐ H2000	Service Fac Initial Comprehensive Visit
☐ T1999	Assistive Technology Only	☐ S5185	PERS Medication Monitoring	☐ S5116	Service Fac Management Training Hrs
☐ T1000	Congregate Nursing/RN	☐ S5161	PERS Monitoring	☐ T1028	Service Fac Reassessment Visit
☐ T1001	Congregate Nursing/LPN	☐ H2021	PERS Nursing Svcs/LPN or RN	☐ 99509	Service Fac Routine Visit
☐ T1030	Congregate Respite Nursing/RN	☐ T1019	Personal Care	☐ T1003	Skilled Nursing Services/LPN
☐ T1031	Congregate Respite Nursing/LPN	☐ T1005	Respite Care	☐ T1002	Skilled Nursing Services/RN
☐ 99199	Environmental Mod, Maint Costs Only	☐ S9125	Respite Care LPN	☐ H2015	Transition Coordination
☐ S5165	Environmental Modifications Only	☐ S5109	Service Facilitation Training Visit		

Substance Use Disorder (SUD) Procedure Codes

Please select the service codes you provide. Please check all that apply.

Procedure Code	Description	Procedure Code	Description
☐ H0011, Rev 1002	Inpatient Acute	☐ H0006	SUD Case Management
☐ H0010, H2034, H2036, Rev 1002	Residential Services	☐ H0007	SUD Crisis Intervention
☐ H0035, Rev 0913	Partial Hospitalization	☐ H0038, T1012, S9445, S9446	SUD Peer Recovery Supports
☐ H0015	Intensive Outpatient (IOP)	☐ CPT Codes	Outpatient SUD – Indiv, Family & Grp Svcs
☐ H0014, H0020, G9012, CPTs 99205 & 99215	Medication Assisted Treatment (MAT) - Suboxone or Methadone Clinic Suboxone Office-Based Treatment	☐ Q3014	SUD Telehealth

Non-Traditional Mental Health Services Procedure Codes

Please select the service codes you provide. Please check all that apply.

Procedure Code	Description	Procedure Code	Description
☐ H2023	Mental Health Case Management	☐ H0035 HB	Day Treatment/ Partial Hospitalization for Adults
☐ H0024	Peer Support Services, Individual Mental Health	☐ H0036	Crisis Intervention
☐ H0025	Peer Support Services, Group Mental Health	☐ H0039	Intensive Community Treatment
☐ H0031	IIH Assessment	☐ H0046	Mental Health Skill-building Services (MHSS)
☐ H0032 U6	Psychosocial Rehab Assessment	☐ H2012	Intensive In-Home
☐ H0032 U7	Therapeutic Day Treatment (TDT) Assessment, Child	☐ H2017	Psychosocial Rehab
☐ H0032 U7	Day Treatment/Partial Hospitalization Assessment Adult	☐ H2019	Crisis Stabilization
☐ H0032 U8	MHSS Assessment	☐ H2033	Multisystemic Therapy (ABA)
☐ H0032 U9	ICT Assessment	☐ H0038, T1012	Peer Support Services- Individual
☐ H0032 UA	Behavioral Therapy Assessment	☐ S9445, S9446	Peer Support Services- Group
☐ H0035 HA	Therapeutic Day Treatment (TDT) for Children	☐ T1016	Treatment Foster Care Case Management
☐ H0035 HA & U7	TDT Summer Program for Children	☐ H2022	Level A Group Home
☐ H0035 HA & UG	TDT Afterschool Program for Children	☐ H2020	Level B Group Home

Other Practice Locations

#2	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	
#3	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	

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Other Practice Locations

#4	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	
#5	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	
#6	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	
#7	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	
#8	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	
#9	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: ☐ YES ☐ NO
	Have 24 hour Access: ☐ YES ☐ NO	Office Hours:	
	Office Contact Name:	Office Contact Email:	

Please use additional sheets as needed for additional locations.

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