MOLINA HEALTHCARE
Your Extended Family.

Guide to Provider Forms

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED
Add a Provider to the group	• PIF – Complete Section A, Section N* and Section O * Section N can be copied when adding multiple providers • Attachment A (Primary Care Providers) • Attachment B (Non-Primary Care Providers, Specialists, Dental and Ancillary Providers) • Attachment D (All Providers) • CAQH (if applicable)
Individual: Change or add a service location	• PIF – Complete Section A, Section H and Section O • Attachment A (Primary Care Providers) • Attachment B (Non-Primary Care Providers, Specialists, Dental and Ancillary Providers) • Attachment D (All Providers)
Change Phone/Fax	• PIF – Complete Section A, Section F and Section O
Change the Pay-To/ Billing Address	• PIF – Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Group: Change or add a service location	• PIF – Complete Section A, Section G and Section O • Attachment A (Primary Care Providers) • Attachment B (Non-Primary Care Providers, Specialists, Dental and Ancillary Providers) • Attachment D (All Providers) • ADA Attestation Form

Add a new group to the same Tax Identification Number (TIN)	• PIF – Complete Section A • W-9 • Attachment A (Primary Care Providers) • Attachment B (Non-Primary Care Providers, Specialists, Dental and Ancillary Providers) • Attachment D (All Providers) • Sample Claim Form (de-identified)
Change Group Name Only	• PIF – Complete Section A and Section D • Attachment A (Primary Care Providers) with new group name • Attachment B (Non-Primary Care Providers, Specialists, Dental and Ancillary Providers) with new group name • Sample Claim Form (de-identified) • W-9
Change TIN only	• PIF – Complete Section A and Section B • W-9 • Sample Claim Form (de-indentified)
Individual Name Change	• PIF – Complete Section A and Section E • Attachment A (Primary Care Providers) • Attachment B (Non-Primary Care Providers, Specialists, Dental and Ancillary Providers) • Attachment D (All Providers)
Terming a provider	• See Section J for instructions
Provider Directory Update	• PIF – Complete Section A and Section L
Panel Update	• PIF – Complete Section A and Section K
Hospital Affiliations Update	• PIF – Complete Section A and Section M
Group/Provider NPI change	• PIF – Complete Section A and Section C

FORMS:	FORM USAGE:
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare.
Attachment A	This form is used for Primary Care Providers (PCPs) who want membership assigned to them. (IM, PED, GP, FP, FM, OB/GYN)
Attachment B	This form is used for Specialists, including RNs, PAs, NPs, Dental and Ancillary Providers.
Attachment D	This form is used to determine the types of services the provider offers.
W-9	This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name, and Tax ID when received with a PIF.
ADA Attestation Form	Providers use this form to attest to their compliance with American Disabilities Act (ADA) requirements for each physical service location.
Credentialing - Individual Providers	**YOU WILL NEED TO…**
If you have a CAQH number	Complete CAQH Provider Data Form. You also need to update and give Molina Healthcare permission to review. Visit the website at http://www.caqh.org.
If you do not have a CAQH number	Go to http://www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review.
Credentialing - Facilities and Other Providers	**YOU WILL NEED TO …**
Including Hospitals, Ambulatory Surgical Centers, Home Health Agencies, Durable Medical Equipment (DME) Suppliers, SNFs, Urgent Care Centers, and Retail Clinics	Print, complete, fax, email or mail the Ohio Department of Insurance Standardized Credentialing Form Part B (Molina Healthcare refers to this as "HDO"). This form can also be found at Quicklinks located at http://www.insurance.ohio.gov. Molina Healthcare of Ohio Attention: PIM P.O. Box 349020 Columbus, OH 43234-9904 Fax: (866) 713-1893 Email: MHOProviderUpdates@MolinaHealthCare.com
CONTACT INFORMATION	If you have additional questions please contact Molina Healthcare's Provider Services department at (855) 322-4079 between the hours of 8 a.m. to 5 p.m. EST, Monday through Friday.

MOLINA HEALTHCARE
Your Extended Family.

Provider Information Update Form (PIF)

Submission Date _____/_____/_____

This form and the associated documentation are required to notify Molina Healthcare of Ohio of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at www.MolinaHealthcare.com.

Type of Group/Provider (Select all that apply):

☐ PCP ☐ Specialist ☐ Dental ☐ BH - Private Practice ☐ BH - CMHC/SUD

☐ Ancillary ☐ LTSS ☐ FQHC/RHC ☐ QFPP/Title X ☐ Urgent Care ☐ Hospital

CMHC/SUD Agencies Only: DO NOT USE THIS PIF DOCUMENT. Please submit a BH Rendering Provider Template, found on the Molina provider website under the "Forms" tab, for any changes related to your CMHC/SUD NPI(s).

SECTION A

Current Group/Practice Information (*All fields in this section are required*)

Group/Practice Name: _____

Group/Practice Tax ID: _____ Group/Practice Medicaid #: _____

Group/Practice NPI #: _____ Contact Number: _____

Email address: _____ Contact Name: _____

Tax Exempt ☐ Yes ☐ NO

Group/Practice Add, Name Change, Tax ID Number Change and NPI Change

If changing the Group/Practice Name, an Amendment is required. If changing both the Group/Practice Name and the Tax ID Number, a new contract is required. Please contact Molina Healthcare Provider Services at (855) 322-4079. A representative will be available to assist you Monday through Friday, 8 a.m. - 5 p.m EST.

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SECTION B

Tax ID Number Change Effective Date _____/_____/_____

Previous Tax ID Number: _____ New Tax ID Number: _____

Return to first page.

SECTION C

Group/Individual NPI Change Effective Date _____/_____/_____

☐ **Group** ☐ **Individual**

Group/Individual Name: _____

Previous NPI: _____

New NPI: _____

Return to first page.

SECTION D

Group/Practice Name Change Effective Date _____/_____/_____

Previous Group/Practice Name: _____ Medicaid #: _____

New Group/Practice Name: _____ Medicaid #: _____

Return to first page.

OTHER CHANGES

SECTION E

Individual Name Change Effective Date _____/_____/_____

Previous Name: _____ New Name: _____

Return to first page.

SECTION F

Change Phone/Fax Effective Date _____/_____/_____

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

Return to first page.

Section G (Group)

☐ **Add a Service Location** Effective Date _____/_____/_____

☐ **Change a Service Location**

Is location closing: Y ☐ N ☐

Please complete the ADA Attestation Form for all new Service Locations.

Previous Address	**New Address**
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Email: _____	Email: _____

Return to first page.

Section H (Individual)

☐ **Add a Provider to a Service Location** Effective Date _____/_____/_____

☐ **Change Service location for a Provider**

Previous Address	**New Address**
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Email: _____	Email: _____

Return to first page.

SECTION I

Billing Address Change Effective Date _____/_____/_____

Previous Billing Information	New Billing Information
Billing Contact: _____	Billing Contact: _____
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

- Is this a Notice Address Change? ☐ No ☐ Yes

The notice Address is the particular party's address for delivery or mailing of notice purposes.

Return to first page.

SECTION J

Terminating a Provider

A termination letter is required on company letterhead and must include the following: Group name, Group Tax ID, Group NPI, name of the provider to be termed, Provider NPI, effective date of termination, reason for termination and address of practice location(s). If terming provider is a PCP, name of provider that will assume patient panel.

Return to first page.

SECTION K

Panel Update Effective Date _____/_____/_____

☐ Existing Patients ☐ Only Close Panel to all Members ☐ Open Panel

Reason: *(Required)* _____

Return to first page.

SECTION L

Provider Directory Update Effective Date _____/_____/_____

☐ Include in Provider Directory ☐ Exclude from Provider Directory

Reason: *(Required)* _____

Return to first page.

SECTION M

Hospital Affiliations Update Effective Date _____/_____/_____

☐ Add Hospital Affiliation(s) ☐ Remove Hospital Affiliation(s)

Names of Hospital(s): _____

Return to first page.

SECTION N

Provider Joining a Group/Practice Effective Date _____/_____/_____ Locum Tenen: ☐ Y ☐ N

Provider Name (Last, First, MI):_____

Provider Type (MD, DO, DC, DDS, DPM, etc): _____ Date of Birth: _____

Last Four Digits of Social Security #: _____ Provider Ethnicity:

☐ African American ☐ Caucasian

☐ Asian/Pacific Islander ☐ Hispanic

☐ Alaskan/American Indian ☐ Other

Individual Provider NPI Number: _____ CAQH Provider Number: _____

Note: Please ensure the provider has completed and/or re-attested to the CAQH Application and Authorized Molina Healthcare to access CAQH.

OH Medicaid Number: _____ OH Medicare Number: _____

Specialty: _____ Secondary Specialty: _____

Applying as: ☐ PCP ☐ Specialist ☐ Hospitialist ☐ Other

For Behavioral Health Providers: Are you individually accessbile by appointment? ☐ Yes ☐ No

Board Certified: ☐ Yes ☐ No Effective Date _____/_____/_____ Expiration Date _____/_____/_____

Certification Board: _____

Group/Practice Name: _____

Group/Practice Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

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Section O

Office Hours

	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Return to first page.

If you have any questions, visit our website at www.MolinaHealthcare.com or call Provider Services at (855) 322-4079. Representatives are available to assist you Monday through Friday from 8 a.m. to 5 p.m.

Please mail, fax or email this form and supporting documentation to:

Molina Healthcare of Ohio
Attn: PIM
P.O. Box 349020 Columbus, OH 43234-9904
Fax (866) 713-1893
MHOProviderUpdates@MolinaHealthcare.com

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Attachment A
Primary Care Providers

Provider Group Name: _____ MCP Name: Molina Healthcare of Ohio, Inc.

Group Tax ID Number: _____

Last	First	MI	Deg	Specialty	Service Location Name	Address	City	St	Zip	County	Group NPI	Capacity

MCP acknowledges changes on the date received. Effective Date to be determined by the MCP. "Capacity" represents the maximum number of the MCP's Medicaid members the primary care provider (PCP) agrees to serve. Each PCP's name must be listed. PCPs, whether individually or as part of a group, must serve a minimum of 50 of the MCP's Medicaid members at each practice location in order to be listed in MCP's provider directory. Please indicate a numeric capacity value instead of "unlimited" or similar response. For any given PCP, total capacity must not exceed 2,000 across all locations. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3).

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Attachment B
Non-Primary Care Providers

Provider Group Name: _____ MCP Name: Molina Healthcare of Ohio, Inc.

Group Tax ID Number: _____

Last	First	MI	Deg	Specialty	Service Location Name	Address	City	St	Zip	County	Group NPI

MCP acknowledges changes on the date received. Effective Date to be determined by the MCP. Each provider's name must be listed. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3).

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Attachment D
Services Provided

Provider Group Name: _____ MCP Name: Molina Healthcare of Ohio, Inc.

Group Tax ID Number: _____

Location NPI: _____

Provider agrees to provide services as enumerated below (specify below):

☐ Ambulance transportation	☐ Mental health and/or substance abuse services
☐ Ambulette transportation	☐ Nursing facility services
☐ Ambulatory Surgery Center	☐ Obstetrical and/or gynecological services
☐ Advanced practice nurse services specify:	☐ Ophthalmology services
☐ Chiropractic services	☐ Outpatient hospital services
☐ Dental services	☐ Physical and occupational therapy
☐ Durable medical equipment (DME)	☐ Podiatry services
☐ Emergency Services	☐ Pharmacy
☐ Family planning services and supplies	☐ Physician services
☐ Federally Qualified Health Center services	☐ Primary care provider services
☐ Home health services/Private Duty Nursing	☐ Renal dialysis
☐ Hospice care	☐ Rural Health Clinic services
☐ Medical Imaging	☐ Specialty physician services, Specify (e.g., cardiology, allergy, etc):
☐ Inpatient hospital services	☐ Speech and hearing services
☐ Laboratory services	☐ Vision (optical) services, including eyeglasses
☐ Other – please specify:	

Behavioral Health Services

BH Provider Type:	☐ Community Mental Health Center / Type 84 ☐ Substance Use Disorder / Type 95 ☐ Non-Type 84/95 BH Provider
Services	
☐ Pharmacological Management	☐ Ambulatory Detox
☐ Behavioral Health Assessment	☐ Targeted Case Management for AOD
☐ Behavioral Health Counseling and Therapy	☐ Intensive Outpatient
☐ Crisis Intervention	☐ Laboratory urinalysis
☐ Partial Hospitalization	☐ Med–Somatic

☐ Community Psychiatric Support Treatment	☐ Methadone Administration
☐ Opioid Treatment Provider	☐ Behavioral Health Respite
☐ Individual Placement & Support / Supported Employment (IPS/SE)	☐ Peer Recovery Support
☐ Assertive Community Treatment (ACT)	☐ Intensive Home Based Treatment (IHBT)
☐ Substance Use Disorder Residential	☐ Mental Health Group Day Treatment
☐ Other – please specify:	

Home and Community Based Services (included only in the MyCare Ohio benefit package)
** Indicates service provider types which may be counted in more than 1 county or region. All others may only count in the county where the provider is physically located.*

BH Provider Type:	☐ Community Mental Health Center / Type 84 ☐ Substance Use Disorder / Type 95 ☐ Non-Type 84/95 BH Provider
Services	
☐ Out of Home Respite Services	☐ Waiver Nursing Services
☐ Adult Day Health Services	☐ Home Delivered Meals*
☐ Waiver Transportation*	☐ Assisted Living Services
☐ Chore Services*	☐ Home Care Attendant
☐ Social Work Counseling	☐ Choices Home Care Attendant
☐ Emergency Response Services*	☐ Enhanced Community Living Services
☐ Home Modification Maintenance and Repair*	☐ Nutritional Consultation
☐ Personal Care Services	☐ Independent Living Assistance
☐ Homemaker Services	☐ Community Transition Services
☐ Pest Control*	☐ Alternative Meals Service
☐ Home Care Attendant Nursing	
☐ Home Medical Equipment and Supplemental Adaptive and Assistive Device Services*	

Effective Date to be determined by the MCP.

Return to first page.

ADA Attestation Form

Please complete the following attestation for each provider service location and return it with your signed contract or completed Provider Information Update Form (PIF), as applicable.

Provider Organization Name: _____ **Tax ID #:** _____

Address: _____ **Phone:** _____

Email Address: _____

The American Disabilities Act (ADA) and Ohio Administrative Code (OAC) 3781.111 require providers make reasonable access and accommodations for all persons with disabilities. Molina Healthcare has been visiting contracted primary care provider (PCP) and specialty care provider service locations to verify core elements of ADA compliance for the MyCare Ohio program.

To assist with completing the assessments in time to publish ADA compliant provider service locations, Molina is providing you with the opportunity to self-attest to the below ADA standards. P**lease check the applicable box next to each standard, have the designated representative sign, and return the attestation to Molina Healthcare.**

ADA STANDARDS	YES	NO
Building has handicap designated parking. Parking spaces are accessible with ramps and curb cutouts between the parking lot, office, and at drop off locations.		
Building has automatic entry option or alternative access method.		
Building has elevator for public use (if building is multi-leveled). Elevator has enough room for the wheelchair and/or scooter to maneuver.		
Restroom is equipped with large stall and safety bars or other reasonable accommodations.		
Waiting room (including furniture) can accommodate patients with physical and non-physical disabilities. The reception and waiting areas have enough room for a wheelchair and/or scooter to maneuver and turn around.		
At least one exam room can accommodate patients with physical and non-physical disabilities.		
Signage and way finding is clear (i.e., color and symbol signage).		
Doors to access building, office, and patient rooms are at least 32 inches wide.		
The exam table moves up and down to make it easier to get on and off whether standing or using a wheelchair or scooter.		
Diagnostic equipment can accommodate patients with disabilities.		
The scale is able to accommodate a wheelchair or scooter.		

Provider service locations that attest to being ADA compliant or have received an in-office assessment and determined to be ADA compliant will be published as such in the Molina MyCare Ohio Provider Directory.

I attest to the best of my knowledge that the above information is true, accurate and complete.

Name: _____ Signature: _____

Title: _____ Date: _____

If you have any questions or concerns, please contact Molina Healthcare Provider Relations at (855) 322-4079. Thank you for your prompt response.