# Non-Par Provider Contract Request Form

If you are not currently a contracted provider with Molina Healthcare of Illinois and are interested in joining our network of quality health care providers, please email the completed form to MHILProviderNetworkManagement@MolinaHealthcare.com.

**If you are joining a contracted group, please do not complete or submit this form. On the Molina Healthcare website, refer to the "Guide to Provider Changes" which can be found on the Forms page.**

Provider Name: _____

Provider Type/Specialty: _____

Medicaid ID Number: _____

Practice Name: _____

*(If your practice is a group practice, please provide the names and specialties of all practitioners in the group. You may attach a separate sheet if necessary.)

Mailing Address: _____

Primary Office Location (if different from mailing address): _____

County: _____ Person Completing This Form: _____

Phone: _____ Provider TIN: _____

Email Address: _____

Are all practitioners employed physicians of the group? **Yes** ☐ or **No** ☐

If **NO:** Please be advised that separate Provider Services Agreements will need to be completed and signed by each practitioner in the group. Further information will be provided via mail.

Any additional information you would like to include relative to your practice: _____

_____

_____

_____

**If your request is approved, you will be contacted by a contract manager within 30 days.**

**If you have any questions regarding completion of this form, email MHILProviderNetworkManagement@MolinaHealthcare.com.**

***Please note that completion of the above information is not confirmation of your participation status with Molina Healthcare of Illinois. Final contractual status is based upon your ability to meet credentialing standards and any additional contractual obligations.

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