

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 the Provider Network Management team at 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 <u>Guide to Provider Changes</u>, which can be found on the <u>Frequently Used Forms</u> page.

Provider Name:
Note : 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.
Provider Type/Specialty:
Medicaid ID Number:
Practice Name:
Mailing Address:
County:Phone:
Provider NPI:Provider TIN:
Group NPI:
Person Completing This Form:
Email Address:
Are all practitioners employed physicians of the group? Yes or No
If no —Please be advised that separate Provider Services Agreements must 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 Molina Contract Manager within 30 days.

 $If you have any questions regarding completion of this form, email the Provider Network Management team at \underline{MHILProviderNetworkManagement@MolinaHealthcare.com.}$

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.