PROVIDER CONTRACT REQUEST FORM

Thank you for your interest in becoming a Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to MHMSProviderContracting@molinahealthcare.com or fax to **(844) 303-5188.**

If you are adding providers to a participating group or PHO/PO, please submit a Provider Information Update Form to MHMSProviderContracting@molinahealthcare.com.

PLEASE SELECT PROVIDER TYPE					
☐ Individual	☐ Medical Group	☐ ASC	☐ Urgent Care	☐ FQHC	☐ RHC
☐ Behavioral Health	☐ Home Health	☐ DME	☐ Dental	☐ Other	

LINE OF BUSINESS					
☐ MSCAN	☐ CHIP	☐ Marketplace			

CONTACT INFORMATION	
Requestor Name: _____	Requestor Phone: _____
Requestor Email: _____	Requestor Fax: _____

PROVIDER INFORMATION	
Legal Entity Name: _____	
Business/Service Address: _____ *(If additional locations please attach roster)*	Mailing address: _____ *(Contract will be emailed)*
City, State, Zip: _____	City, State, and Zip: _____
Office Phone: _____	Contact Phone: _____
Office Fax: _____	Contact Fax: _____
Office Email: _____	Contact Email: _____

PROVIDER IDENTIFICATION	
Group Specialty: _____	Tax ID (TIN): _____
Group Billing NPI(s): _____ ** List all Group NPI(s) applicable to the corresponding Tax ID*	
** Mississippi Medicaid ID Number: _____ *(If MSCAN is selected under LOB, a Medicaid ID is required. If you do not have a group/individual Medicaid ID issued from the Mississippi Division of Medicaid, we will not be able to proceed with a group/individual agreement for MSCAN.)*	
Hospital Affiliation(s): _____	

Once the completed form is submitted, please allow 3-5 business days for a contract packet to be emailed to the contact email you provided above. The contract packet will allow you an opportunity to provide us with additional details about your practice/services to ensure proper contracting and enrollment setup. Application status requests can be emailed to MHMSProviderContracting@molinahealthcare.com

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