

APPLICATION CHECKLIST & INSTRUCTIONS

Please complete the below form and submit it to your Molina Healthcare representative.

Note: Using the CAQH Universal Credentialing Data Source does not constitute applying for participation with any health care organization. Contact your Molina Healthcare representative directly regarding contracting. Please make sure that your CAQH information is current & complete. **Failure to supply all information listed below or to complete all forms entirely will prevent initiation of the credentialing process and will cause delays in the contracting process.**

If you already participate in CAQH:

- * Molina must have access to a completed application attested to w/in the past 120 days.
- * You must give Molina Healthcare authorization to use your CAQH application.
- * *Failure to do ALL of these steps will prevent initiation of the credentialing process.*

If you would like to participate in CAQH:

- * Submit the information on the attached Provider Information Form to your Molina representative
- * Molina will submit your information to CAQH to create your account and obtain a CAQH ID.
- * Here are the steps to get started: <https://upd.caqh.org/OAS/GettingStarted.aspx>
- * You may access the general CAQH website at <https://upd.caqh.org/oas>.
- * You must complete the CAQH application in its entirety and give Molina authorization to use it.
- * You must notify your Molina representative once your application is complete and available.
- * Failure to do ALL these steps will prevent initiation of the credentialing process.

The following documents are required in order to complete your credentialing.

You must *always* include these documents:

- Completed Practitioner Information Form (attached, pg. 2)
(Failure to complete in its entirety for each practitioner to be credentialed will prevent initiation of credentialing)
- Completed Ownership/Controlling Interest Disclosure Form
http://www.molinahealthcare.com/medicaid/providers/nm/pdf/nm_disclosure_form_v1_1_pdf.
(Failure to complete in its entirety for each practitioner to be credentialed will prevent initiation of credentialing)
- For Physician Assistants ONLY: A copy of the first two pages of your supervising physician agreement
<http://www.nmmb.state.nm.us/pdffiles/SupervisingPhysicianSR.pdf>
- W9 and IRS letter for Tax Identification Number (TIN)

If you do not utilize CAQH, you must *always* include these documents or credentialing cannot be initiated:

- Complete credentialing application w/ Molina specific attestation (**signed within 120 days**)
(Must be completed for each practitioner to be credentialed & attested within the past 120 days)
- Copy of curriculum vitae or resume
(Only required if application references the CV/Resume or has date gaps)
- Copy of W-9 form(s)
(for ALL practice groups that will be contracted with Molina for each practitioner)
- Copy of **CURRENT** professional liability malpractice insurance face sheet
(for ALL practice groups that will be contracted with Molina for each practitioner)
- Copy of certificates for conducting x-ray and/or laboratory service(s)
(for ALL practice groups that will be contracted with Molina for each practitioner)
- Copy of a State-issued Medicaid enrollment confirmation letter (showing organization enrollment)

PRACTITIONER INFORMATION FORM

Provide the following details ONLY in relation to your intended affiliation with Molina Healthcare of New Mexico. Attach any necessary addendums showing additional practice information (e.g., groups, addresses, etc.).

PRACTITIONER INFORMATION (to be used for contracting w/ Molina Healthcare): Start/Hire Date: _____

| | | |
|---|--|---|
| Status w/ CAQH: <input type="checkbox"/> I am participating <input type="checkbox"/> I would like to participate <input type="checkbox"/> I do not want to participate | CAQH ID Number: (if already participating) Individual NPI: | |
| Last Name: | First Name: | Middle Initial: |
| Provider Type: (MD, PT, etc.) | Date of Birth: | Last 4 Digits of SSN: |
| Directory Category: | <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied/Ancillary Provider Directory: <input type="checkbox"/> YES <input type="checkbox"/> NO Accepting New Members: <input type="checkbox"/> YES <input type="checkbox"/> NO Prescriptive Authority (RX) <input type="checkbox"/> YES <input type="checkbox"/> NO | Molina requires electronic claims submission. Will you be able to submit claims electronically? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Providing telemedicine services to Molina members from a New Mexico practice location/site: <input type="checkbox"/> YES <input type="checkbox"/> NO | Providing telemedicine services to Molina members from locations/sites outside of NM: <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Primary Specialty (w/ Molina Healthcare): | | |
| Secondary Specialties (w/ Molina Healthcare): | | |

PRIMARY PRACTICE INFORMATION (to be used for contracting w/ Molina Healthcare):

| | | | |
|--|---|---------|------|
| Practice Type: <input type="checkbox"/> Solo Practice <input type="checkbox"/> Group/Clinic Practice <input type="checkbox"/> Hospital Employee | Facility Accredited <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A (if not solo): Accredited with (if accredited): | | |
| Group/Facility Name (if not solo): | Group NPI (if not solo): | | |
| Age/Gender/Other Practice Limitations: | Tax ID # (TIN): | | |
| Physical Street Address: (City, State, Zip) | Suite/Floor: | | |
| City: | State: | County: | ZIP: |
| Phone: | Fax: | E-mail: | |
| Office Hours: | | | |
| Mailing Address: | | | |
| City: | State: | ZIP: | |
| Credentiaing Contact Name: | Phone: | E-mail: | |