

INSTRUCTIONS:

Complete all items as noted below and submit this application and attachments to your contracting representative in order to apply for credentialing with Molina Healthcare, Inc. (Molina Healthcare) in your respective State. Please note that completed and approved credentialing is required prior to completion of a contract for any organization/facility not currently contracted with Molina Healthcare, and that approval of your credentialing does not constitute finalization/approval of your contract and network participation.

- **A separate application is required for:**
 - each location (or group of locations) that shares CMS certification under one primary specialty
 - each location (or group of locations) that shares accreditation (on pg. 5) under one primary specialty
 - each location (or group of locations) that has a different primary specialty

- **This application must be filled out completely with all sections answered:**
 - Do not use white-out on any part of the application.
 - If there is NOT a checkbox in the section header to indicate a why a section is not applicable, the section should be completed by ALL applicants.
 - Section 6 MUST be completed by all applicants.

- **The information listed below should accompany the completed application:**
 - Current organizational or facility licenses/certifications/registrations
 - (If above is unavailable: attach a list of individual service provider names, specialties & license numbers)
 - Current professional liability insurance face sheet (or general liability if professional is unavailable)
 - W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility
(Only Page 1 of this form is needed: <http://www.irs.gov/pub/irs-pdf/fw9.pdf>)
 - Completed ownership/controlling interest disclosure form
(This form can be supplied by your contracting or credentialing representative)

- **If your organization is not accredited by a body listed in Section 5 of this application and your organization is required to be certified by CMS or the State, we also request one of the following documents:**
 - A copy of the most recent CMS or State on-site survey results
 - A copy of the letter verifying approval of CMS participation

- ***Incomplete applications will be returned for completion prior to processing.***

- ***Please return this application and all attachments to the location specified on your cover letter.***



1. ORGANIZATION INFORMATION:
(Provide physical location information on the following page)

Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # <i>(primary)</i> :	Organization Medicaid # <i>(primary)</i> :
Organization TIN <i>(primary)</i> :	Organization NPI <i>(primary)</i> :
Ownership Type (select one)	<input type="checkbox"/> Sole proprietorship <input type="checkbox"/> City/County/State owned <input type="checkbox"/> Corporation/LLC/Partnership <input type="checkbox"/> Federally owned
Credentialing Address <i>(Enter Mailing Address if no Credentialing Address)</i>	Billing Address <i>(if different than Credentialing/Mailing)</i>
Street Address: _____	Street Address: _____
Address Line 2: _____	Address Line 2: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Contact: _____	Contact: _____
Email: _____	Email: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

2. CURRENT INSURANCE COVERAGE:
(Please attach a copy of your current facility professional/general liability insurance face-sheet)

<input type="checkbox"/> Please check here if your facility is not required to carry liability insurance.		
Professional Liability Insurance Information (if available)		
Current Carrier Name:	Policy Number:	
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:	Coverage amount aggregate:	
General Liability Insurance Information (if no professional liability available)		
Current Carrier Name:	Policy Number:	
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:	Coverage amount aggregate:	



COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

ONLY include information for locations that you wish to be listed with Molina Healthcare

Complete a copy of sections 3-5 of this application for EVERY location where information differs between locations

3. PHYSICAL LOCATION INFORMATION:
(Include any additional information relevant to this location on a separate sheet)

Location DBA
(if different than the Organization DBA)

Other DBAs Previously Used
(if under same ownership)

Is this location Medicare Certified? Yes No Is this the primary address? Yes No

Site-specific Medicare #: _____ Site-specific Medicaid #: _____

Site-specific TIN: _____ Site-specific NPI: _____

Physical Practice Location State provider # (if applicable, LTC, etc.): _____

Street Address: _____ Is this location handicap accessible? Yes No

Address Line 2: _____ Describe your service area (States, Counties, Cities, etc.): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please list any languages spoken by office personnel:

Practice Limitations (e.g., age, gender, etc.):

Location State License(s) and/or State Registration(s) – (Attach a copy of all)

Please check here if this location is not required to be licensed, certified, or registered by a State agency.

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – (Attach a copy of all)

Please check here if this location holds no additional licenses, certificates, registrations, etc.

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

LICENSED Healthcare Practitioner Information – (Only needed for licensed practitioners, and only if location is not surveyed/accredited and holds no licenses/certificates/registrations)

Name	NPI	Date of Birth	Specialty	License #

4. PRIMARY CONTRACTED SPECIALTY & TAXONOMY:

*(If each location will be contracted for a different specialty, complete a separate full application for each location)
 (If there are multiple primary specialties being contracted with Molina, check ALL that apply)*

Specialty & Federal Taxonomy Code		Specialty & Federal Taxonomy Code	
Agencies			
<input type="checkbox"/>	Case Management [251B00000X]	<input type="checkbox"/>	Hospice - Community Based [251G00000X]
<input type="checkbox"/>	Day Training - Developmentally Disabled Services [251C00000X]	<input type="checkbox"/>	In Home Supportive Care [253Z00000X]
<input type="checkbox"/>	Early Intervention Provider [252Y00000X]	<input type="checkbox"/>	Nursing Care [251J00000X]
<input type="checkbox"/>	Foster Care [253J00000X]	<input type="checkbox"/>	All-Inclusive Care for the Elderly (PACE) [251T00000X]
<input type="checkbox"/>	Home Health [251E00000X]	<input type="checkbox"/>	Public Health [251K00000X]
<input type="checkbox"/>	Home Infusion [251F00000X]	<input type="checkbox"/>	Supports Brokerage [251X00000X]
Ambulatory Care Clinics/Centers			
<input type="checkbox"/>	Adolescent & Children Mental Health [261QM0855X]	<input type="checkbox"/>	Occupational Therapy [261QX0100X]
<input type="checkbox"/>	Day Care - Adult [261QA0600X]	<input type="checkbox"/>	Oncology - Radiation [261QX0203X]
<input type="checkbox"/>	Adult Mental Health [261QM0850X]	<input type="checkbox"/>	Ophthalmologic Surgery [261QS0132X]
<input type="checkbox"/>	Ambulatory Family Planning [261QA0005X]	<input type="checkbox"/>	Oral and Maxillofacial Surgery [261QS0112X]
<input type="checkbox"/>	Ambulatory Surgical Center [261QA1903X]	<input type="checkbox"/>	Physical Therapy [261QP2000X]
<input type="checkbox"/>	Amputee Center [261QA0900X]	<input type="checkbox"/>	Public Health - Federal [261QP0904X]
<input type="checkbox"/>	Augmentative Communication [261QA3000X]	<input type="checkbox"/>	Public Health - State or Local [261QP0905X]
<input type="checkbox"/>	Birthing Center [261QB0400X]	<input type="checkbox"/>	Radiology [261QR0200X]
<input type="checkbox"/>	Critical Access Hospital [261QC0050X]	<input type="checkbox"/>	Radiology - Mammography [261QR0206X]
<input type="checkbox"/>	Emergency Care [261QE0002X]	<input type="checkbox"/>	Radiology - Mobile [261QR0208X]
<input type="checkbox"/>	Endoscopy [261QE0800X]	<input type="checkbox"/>	Rehabilitation (PT/OT/ST) [261QR0400X]
<input type="checkbox"/>	End-Stage Renal Disease (ESRD)/Dialysis [261QE0700X]	<input type="checkbox"/>	Rehabilitation - Cardiac [261QR0404X]
<input type="checkbox"/>	Federally Qualified Health Center (FQHC) [261QF0400X]	<input type="checkbox"/>	Rehabilitation - Outpatient (CORF) [261QR0401X]
<input type="checkbox"/>	Infusion Therapy Clinic [261QI0500X]	<input type="checkbox"/>	Rehabilitation - Substance Use Disorders [261QR0405X]
<input type="checkbox"/>	Lithotripsy [261QL0400X]	<input type="checkbox"/>	Rural Health Clinic (RHC) [261QR1300X]
<input type="checkbox"/>	Magnetic Resonance Imaging (MRI) [261QM1200X]	<input type="checkbox"/>	Speech Therapy [261QH0700X]
<input type="checkbox"/>	Day Care - Medically Fragile Infnts/Chldrn [261QM3000X]	<input type="checkbox"/>	Urgent Care [261QU0200X]
<input type="checkbox"/>	Mental Health - Outpatient [261QM0801X]		
Hospitals			
<input type="checkbox"/>	Chronic Disease [281P00000X]	<input type="checkbox"/>	Long Term Care [282E00000X]
<input type="checkbox"/>	Chronic Disease - Children [281PC2000X]	<input type="checkbox"/>	Psychiatric [283Q00000X]
<input type="checkbox"/>	General Acute Care [282N00000X]	<input type="checkbox"/>	Rehabilitation [283X00000X]
<input type="checkbox"/>	General Acute Care - Children [282NC2000X]	<input type="checkbox"/>	Rehabilitation - Children [283XC2000X]
<input type="checkbox"/>	General Acute Care - Critical Access [282NC0060X]	<input type="checkbox"/>	Religious Nonmedical Health Care [282J00000X]
<input type="checkbox"/>	General Acute Care - Rural [282NR1301X]	<input type="checkbox"/>	Specialty [284300000X]
<input type="checkbox"/>	General Acute Care - Women [282NW0100X]		
Laboratories			
<input type="checkbox"/>	Clinical Medical [291U00000X]	<input type="checkbox"/>	Physiological (Independent Diagnostic/IDTF) [293D00000X]
<input type="checkbox"/>	Dental [292200000X]		
Nursing/Custodial Care Organizations			
<input type="checkbox"/>	Assisted Living [310400000X]	<input type="checkbox"/>	Intermediate Care - Mental Illness [310500000X]
<input type="checkbox"/>	Assisted Living - Bhvrl Disturbances [3104A0630X]	<input type="checkbox"/>	Intermediate Care - Mental Retarded [315P00000X]
<input type="checkbox"/>	Assisted Living - Mental Illness [3104A0625X]	<input type="checkbox"/>	Intermediate Care - Nursing [313M00000X]
<input type="checkbox"/>	Custodial Care [311Z00000X]	<input type="checkbox"/>	Skilled Nursing [314000000X]
<input type="checkbox"/>	Hospice - Inpatient [315D00000X]	<input type="checkbox"/>	Skilled Nursing - Pediatric [3140N1450X]



**Molina Healthcare, Inc.
Health Delivery Organization (HDO) Application**

4. PRIMARY CONTRACTED SPECIALTY & TAXONOMY – Continued:
*(If each location will be contracted for a different specialty, complete a separate full application for each location)
 (If there are multiple primary specialties being contracted with Molina, check ALL that apply)*

Specialty & Federal Taxonomy Code		Specialty & Federal Taxonomy Code	
Residential Care Organizations			
<input type="checkbox"/>	Community Based - Mental Illness [320800000X]	<input type="checkbox"/>	Physical Disabilities [320700000X]
<input type="checkbox"/>	Community Based - Mental/Dvlpmntl Dsblts [320900000X]	<input type="checkbox"/>	Psychiatric [323P00000X]
<input type="checkbox"/>	Emotionally Disturbed Children [322D00000X]	<input type="checkbox"/>	Rehabilitation - Substance Abuse [324500000X]
<input type="checkbox"/>	Mental Retardation/Dvlpmntl Disabilities [320600000X]	<input type="checkbox"/>	Rehabilitation - Children [3245S0500X]
Respite Care Organizations			
<input type="checkbox"/>	General [385H00000X]	<input type="checkbox"/>	Mental Retardation/Developmental Disabilities [385HR2060X]
<input type="checkbox"/>	Camp [385HR2050X]	<input type="checkbox"/>	Physical Disabilities - Children [385HR2065X]
<input type="checkbox"/>	Mental Illness - Children [385HR2055X]		
Suppliers			
<input type="checkbox"/>	Blood Bank [331L00000X]	<input type="checkbox"/>	Eye bank [332G00000X]
<input type="checkbox"/>	Durable Medical Equip [332B00000X]	<input type="checkbox"/>	Eyewear [332H00000X]
<input type="checkbox"/>	Durable Medical Equip - Customized [332BC3200X]	<input type="checkbox"/>	Hearing Aid Equipment [332S00000X]
<input type="checkbox"/>	Durable Medical Equip - Dialysis [332BD1200X]	<input type="checkbox"/>	Home Delivered Meals [332U00000X]
<input type="checkbox"/>	Durable Medical Equip - Nursing [332BN1400X]	<input type="checkbox"/>	Medical Food [335G00000X]
<input type="checkbox"/>	Durable Medical Equip - Oxygen/Respiratory [332BX2000X]	<input type="checkbox"/>	Organ Procurement [335U00000X]
<input type="checkbox"/>	Durable Medical Equip - Parental/Enteral Ntrtn [332BP3500X]	<input type="checkbox"/>	Pharmacy [333600000X]
<input type="checkbox"/>	Emergency Response Services [333300000X]	<input type="checkbox"/>	Portable X-ray [335V00000X]
Transportation Vendors			
<input type="checkbox"/>	Ambulance [341600000X]	<input type="checkbox"/>	Bus [347B00000X]
<input type="checkbox"/>	Ambulance - Air [3416A0800X]	<input type="checkbox"/>	Non-Emergency Medical (VAN) [343900000X]
<input type="checkbox"/>	Ambulance - Land [3416L0300X]	<input type="checkbox"/>	Secured Medical (VAN) [343800000X]
<input type="checkbox"/>	Ambulance - Water [3416S0300X]	<input type="checkbox"/>	Broker [347E00000X]
Atypical Service Organizations (No Federal Taxonomy)			
<input type="checkbox"/>	Adaptive Assistance Devices [NONE]	<input type="checkbox"/>	Home/Environment Modification [NONE]
<input type="checkbox"/>	Community Health Workers [NONE]	<input type="checkbox"/>	Homemaker Services [NONE]
<input type="checkbox"/>	Community Transition Services - Housing [NONE]	<input type="checkbox"/>	Independent Living Assistance/Adult Companion [NONE]
<input type="checkbox"/>	Core Services Agencies [NONE]	<input type="checkbox"/>	Nutritional Consultation Services [NONE]
<input type="checkbox"/>	Employment Support [NONE]	<input type="checkbox"/>	Personal Care Services [NONE]
<input type="checkbox"/>	Financial Assessment/Risk Reduction Services [NONE]	<input type="checkbox"/>	Pest Control [NONE]
Other Specialties (List the Specialty and Federal or State Taxonomy)			
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

5. ACCREDITATION / CERTIFICATION (check all that apply):
 Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.

 Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.

Accreditation Organization		Date of Last Survey
<input type="checkbox"/> (CMS)	Medicare Certification (<i>attach most recent survey and acceptance letter</i>)	
<input type="checkbox"/> (AAAH)	Accreditation Association for Ambulatory Health Care	
<input type="checkbox"/> (ACHC)	Accreditation Commission for Health Care	
<input type="checkbox"/> (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
<input type="checkbox"/> (ABCOP)	American Board for Certification in Orthotics/Prosthetics	
<input type="checkbox"/> (ACR)	American College of Radiology	
<input type="checkbox"/> (ASHI)	American Society for Histocompatibility and Immunogenetics	
<input type="checkbox"/> (BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)	
<input type="checkbox"/> (CAP)	College of American Pathologists	
<input type="checkbox"/> (CARF)	Commission on Accreditation of Rehabilitation Facilities	
<input type="checkbox"/> (COLA)	Committee of Laboratory Accreditation	
<input type="checkbox"/> (CHAP)	Community Health Accreditation Program	
<input type="checkbox"/> (CT)	The Compliance Team	
<input type="checkbox"/> (COA)	Council on Accreditation	
<input type="checkbox"/> (DNV)	Det Norske Veritas	
<input type="checkbox"/> (HFAP)	Healthcare Facilities Accreditation Program - AOA	
<input type="checkbox"/> (HQAA)	Healthcare Quality Association on Accreditation	
<input type="checkbox"/> (IAC)	The Intersocietal Accreditation Commission	
<input type="checkbox"/> (NABP)	National Association of Boards of Pharmacy	
<input type="checkbox"/> (NBAOS)	National Board of Accreditation for Orthotics Suppliers	
<input type="checkbox"/> (NCQA)	National Commission for Quality Assurance	
<input type="checkbox"/> (TJC)	The Joint Commission	
<input type="checkbox"/> (URAC)	URAC, (aka, American Accreditation Healthcare Commission)	
<input type="checkbox"/> (*CABC)	<i>*Commission for the Accreditation of Birth Centers</i>	
<input type="checkbox"/> (*PPFA)	<i>*Planned Parenthood Federation of America</i>	

*** Molina only recognizes accreditation by CMS 'Deemed' bodies with the exception of the CABC for 'Birthing Centers' and PPFA for 'Planned Parenthood' facilities.**

6. CREDENTIALING PROGRAM (all questions **MUST** be answered by **ALL** organizations):**Organizational Service Provider Screening**(mark **ONE** option for each question)

1) Please select the method utilized to verify the license/certification of individuals rendering services for your organization:

- Online directly with the appropriate State and/or Federal licensure or certification board
- Background check agency, contracted organization, or vendor
- Other process (please describe): _____
- No process (please explain): _____

2) Please indicate the method utilized to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration?

- Online directly with the appropriate State and/or Federal licensure or certification board
- Obtaining a current copy of the license/certification
- Background check agency, contracted organization, or vendor
- Other process (please describe): _____
- No process (please explain): _____

3) Please indicate the method utilized to verify the identity of individuals rendering services for your organization:

- Verification of a state driver's license or other government identification
- Background check agency, contracted organization, or vendor
- Other process (please describe): _____
- No process (please explain): _____

4) Please indicate the method utilized to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a health-care related crime (including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance) are rendering services:

- Federal and/or State Criminal Background Check(s)
- Background check agency, contracted organization, or vendor
- Search a State 'Misconduct Registry' or equivalent
- Other process (please describe): _____
- No process (please explain): _____

6. CREDENTIALING PROGRAM - Continued (all questions **MUST** be answered by **ALL** organizations):

Facility / Organization Disclosure

5) Has your organization or any of its authorized representatives ever been convicted of, pled guilty to, or pled nolo contendere to any legal actions (excluding medical malpractice and misdemeanors)?

NO YES (provide an explanation): _____

6) Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?

NO YES (provide an explanation): _____

7) Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs?

NO YES (provide an explanation): _____

8) At any time, has any license or certification held by the organization or its branch locations ever been revoked, denied or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which may lead to one of these outcomes?

NO YES (provide an explanation): _____

9) Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?

NO YES (provide an explanation): _____

10) At any time, has any third party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management or quality of care issues?

NO YES (provide an explanation): _____

11) Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?

NO YES (provide an explanation): _____



ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant Molina Healthcare permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize Molina Healthcare to request, receive and inspect any and all records pertinent to consideration of this application.

As a Molina Healthcare Plan facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply Molina Healthcare with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:

I hereby grant permission for Molina Healthcare to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support Molina Healthcare's quality improvement and utilization review programs.

ATTESTATION:

I certify the information on this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that decision of participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with Molina Healthcare and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by Molina Healthcare. All services rendered to Molina members must be individually authorized until a written notice of participation and conditions of participation is issued by Molina Healthcare.

This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (http://oig.hhs.gov/exclusions/exclusions_list.asp) and System for Award Management (https://www.sam.gov/portal/public/SAM/) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Signature: _____ (Stamped signature is not acceptable)

Printed Name: _____ Date: _____