



# ENROLLMENT APPLICATION REQUIRED DOCUMENTATION CHECKLIST

Please submit current copies of ALL of the documentation listed below. Any missing or inaccurate information will delay the enrollment process.

- **W-9 form**
- **Disclosure and Ownership Form (Facility Credentialing ONLY)**
- **NYS License**
- **DEA**
- **Proof of Malpractice Insurance**
- **Group Roster**
- **Supervising/Collaboration physician form (midlevels only)**

**We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are not considered in-network.**

# APPLICATION FOR PROVIDER ENROLLMENT



To begin the enrollment process, please complete the information appropriate to your specialty. Complete and return with the items on the attached checklist. All information must match NPPEs.

**Please ensure that your CAQH information is completed and released to us with the most up-to-date information.**

Today's Date:	Requested Effective Date:	Group Name:
Group TAX ID:	Group NPI:	Provider Name:
Individual NPI#:	SSN#:	DOB:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Provider License#/State:	DEA Certificate#:
CAQH#: MEDICAID #:	Accepting new patients?    YES    NO PCP?                                YES    NO Panel?                                OPEN   CLOSE	Language(s) other than English:

**Taxonomy Code (required). Circle One: MD   DO   PA   NP   Other: \_\_\_\_\_**

Primary Specialty:	Taxonomy Code:
Second Specialty:	Taxonomy Code:
Third Specialty:	Taxonomy Code:

**Please note: A correspondence street level address must be applied when a remittance address is a PO Box. Please use additional sheets when needed for multiple addresses.**

<b>Address A</b>	Street: _____ STE: _____ City: _____ State: _____    ZIP Code: _____	<input type="radio"/> <b>Primary Office</b> <input type="radio"/> <b>Additional Office</b> <input type="radio"/> <b>Correspondence</b> <input type="radio"/> <b>Remittance</b> <input type="radio"/> <b>Medical Record</b>
Phone: _____ Fax: _____	<b>Office Hours:</b>	Handicap accessible: Y or N Public Transportation: Y or N
<b>Address B</b>	Street: _____ STE: _____ City: _____ State: _____    ZIP Code: _____	<input type="radio"/> <b>Primary Office</b> <input type="radio"/> <b>Additional Office</b> <input type="radio"/> <b>Correspondence</b> <input type="radio"/> <b>Remittance</b> <input type="radio"/> <b>Medical Record</b>
Phone: _____ Fax: _____	<b>Office Hours:</b>	Handicap accessible: Y or N Public Transportation: Y or N

<b>Address C</b>	Street: _____ STE: _____ City: _____ State: _____ ZIP Code: _____	<input type="radio"/> <b>Primary Office</b> <input type="radio"/> <b>Additional Office</b> <input type="radio"/> <b>Correspondence</b> <input type="radio"/> <b>Remittance</b> <input type="radio"/> <b>Medical Record</b>
Phone: _____ Fax: _____	<b>Office Hours:</b>	Handicap accessible: Y or N Public Transportation: Y or N
<b>Address D</b>	Street: _____ STE: _____ City: _____ State: _____ ZIP Code: _____	<input type="radio"/> <b>Primary Office</b> <input type="radio"/> <b>Additional Office</b> <input type="radio"/> <b>Correspondence</b> <input type="radio"/> <b>Remittance</b> <input type="radio"/> <b>Medical Record</b>
Phone: _____ Fax: _____	<b>Office Hours:</b>	Handicap accessible: Y or N Public Transportation: Y or N

All members can make an appointment and be treated at **Address: A**  **B**  **C**  **D**  Hospitalist at **Address: A**  **B**  **C**  **D**

### OFFICE CONTACT INFORMATION

Please use this space for indicating the best points of contact for each category. All email communications will also be sent to the email listed under “General Molina Updates”

Best contact (Please list name or N/A)	Email	Phone Number
<b>General Molina Updates</b>		
Credentialing-		
Office Manager-		
Quality-		
Clinical-		
Pharmacy-		
Billing-		

**Authorized person completing form:**

Name:	Phone:	Email:
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# Supervising/Collaboration Physician Form

<b>Name of Midlevel:</b>	
<b>NP/PA:</b>	
<b>NPI:</b>	
<b>Name of Supervising/Collab Physician:</b>	
<b>NPI of Physician:</b>	
<b>Effective date:</b>	

**Authorized person completing form:**

Name:	Phone:	Email:
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