Contract Request Form (CRF)

(*Please print legibly.*)

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 fax number: 877-900-5655 Attn: Contracting Team or email form to: mhtcontractrequest@molinahealthcare.com

Please Select Provider Type

___Individual ___Group __Ancillary ___Hospital ___ SNF ____LTAC ___Urgent Care/ER

___Nursing Facility ___ Assisted Living Facility _____LTSS (*specify type)*

___Home Modification ____DME ___PT/OT/SP ____CORF/ORF Other (please specify)_____

☐ ***Check Here if Adding Provider to Existing Group (Please submit current group roster with request)***

Requestor Name: _____ Requestor Phone: _____

Requestor Email: _____ Requestor Fax: _____

Provider Name: _____ Group Name: _____

☐ ***Primary Care Provider designation***

Business/Service Address: _____
(If additional locations please attach roster)

Mailing address: _____
(*Contract will be emailed unless indicated here where to send)*

City, State, Zip: _____ City, State, and Zip: _____

Office Phone: _____ Contact Phone: _____

Office Fax: _____ Contact Fax: _____

Office Email: _____ Contact Email: _____

Specialty:_____ Taxonomy:_____

Tax ID: _____ Bill Type: ____CMS1500 ____UB04 _____Both

Ind. NPI/API:_____ Group NPI/API:_____

Ind. TPI:_____ Group TPI:_____

Ind. Medicare*:_____ Group Medicare*:_____
*(*note: required for contracting)* *(*note: cannot create group contract if no group Medicare)*

Ind. CAQH: _____ DADS Contract #:_____
(if applicable) *(if applicable)*

Date requested:_____

Once completed form is submitted, please allow 3-5 business days for contract packet to be mailed. Included in the contract package will be an opportunity to provide us with more details about your office.