

Application for New Provider Complete and return via FAX (855) 849-1103

Practitioner's complete name				Gender		
Practitioner's PRIMARY specialty				Date of Birth		
Other specialties (secondary) if applicable				Language(s)		
Number of mid-levels in your office						
Mid-level name			Mid-level title	Mid-level title		
Specialist or Primary Care?						
Is Practitioner Hospital or Clinic based?						
Practitioner's title						
Practitioner's NPI#						
Practitioner's Medicaid ID#						
Group's name						
Group's NPI#				Group's TIN#		
Group's Medicaid ID#						
Billing address						
Billing phone and FAX						
Practice location name						
Practice location address						
Practice location phone and FAX						
License#			Medicare ID			
DEA#						
CAQH# (or attach credentialing application)						
Hospital affiliations						
Contact name						
Contact email						
Contact phone						
Unique services provided by practitioner						
Board certified? If not, when will the intent be?						
When did the provider start working in this office?						
Is this practitioner's group accepting new Molina patients?						
How many patients are you actively treating?						
If practitioner is a PCP provider, enter number of patients that are:						
Medicaid	(CHIP		Medicare		