



# Provider Contract Request Form

Molina Healthcare of Washington, Inc.

Thank you for your interest in becoming a **Molina Healthcare of Washington, Inc.**, provider! Please complete this form and return it along with a W-9 to: [MHWProviderContracting@MolinaHealthcare.com](mailto:MHWProviderContracting@MolinaHealthcare.com) for network participation consideration. *Completing this form is not a guarantee of network participation.*

### PROVIDER TYPE (check all that apply)

<input type="checkbox"/> Individual	<input type="checkbox"/> Single Specialty Group	<input type="checkbox"/> Multi-Specialty Group	
Specialty(ies):			
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Hospital	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Home Health	<input type="checkbox"/> DME	<input type="checkbox"/> Laboratory	
<input type="checkbox"/> FQHC	<input type="checkbox"/> RHC	<input type="checkbox"/> Tribal	
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Autism Services	<input type="checkbox"/> SUD / <input type="checkbox"/> MAT	<input type="checkbox"/> Gender Dysphoria <input type="checkbox"/> Eating Disorder
Other:		Facility Based:	<input type="checkbox"/> Yes <input type="checkbox"/> No

### GROUP ADMINISTRATOR CONTACT INFORMATION

Name:	Phone:
Email:	
<input type="checkbox"/> Employee of the Group	<input type="checkbox"/> Consultant / 3 <sup>rd</sup> Party Professional

### GROUP INFORMATION

Legal Name:	
DBA Name:	
<input type="checkbox"/> DBA name is billing name (Box 33 on HCFA / CMS1500)	<input type="checkbox"/> DBA name is service location name (Box 32 on HCFA / CMS1500)
TIN:	Group/Billing NPI*:
Primary Service Location: <i>(Please include roster of additional service locations.)</i>	
Phone:	Fax:
Billing/Remit Address:	

### PRACTITIONER ROSTER (Complete if applicable, please attach separate sheet for additional practitioners.)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Title (MD, DO, etc.) \_\_\_\_\_  
 NPI: \_\_\_\_\_ Age Limits (If yes, please specify): \_\_\_\_\_

**Gender Restrictions**  Yes  No (If yes, please specify): \_\_\_\_\_ **Complete OB Care:**  Yes  No

**Family Planning:**  Yes  No **PCP**  Yes  No **Accepting New Patients**  Yes  No

**Are all practitioners employed by the group and billing under the group TIN identified above?**  Yes  No

*If NO, please be advised that a separate agreement may be required for non-employed practitioners.*

\*Please note: All billing and rendering NPIs MUST be registered with the Washington State Health Care Authority (HCA) prior to credentialing/contracting. All providers must be credentialed AND contracted to be considered in-network participating providers.