Molina Healthcare of New Mexico, Inc.

APPLICATION CHECKLIST & INSTRUCTIONS

Please complete the below and submit to your Molina Healthcare representative, along with all specified attachments, forms and documents.

Note: Contact your Molina Healthcare representative directly regarding contracting. Please make sure that the information supplied on your organizational credentialing application is current & complete. Failure to supply all information listed below or to complete all forms entirely will prevent initiation of the credentialing process, and will cause delays in the contracting process.

The following items are required in order to complete your organizational credentialing.

You must *always* include these documents:

- ☐ Completed Facility Information Form (attached, pg 2)
  (Failure to complete in its entirety for all locations to be credentialed will prevent initiation of credentialing)
- ☐ Completed Organizational Ownership/Controlling Interest Disclosure Form
  (Failure to complete in its entirety for all locations to be credentialed will prevent initiation of credentialing)
- ☐ Complete Organizational Credentialing Application (signed w/in 120 days)
  (Failure to complete in its entirety for all locations to be credentialed will prevent initiation of credentialing)

- ☐ Copy of all organizational licenses, registrations, certificates, etc.
  (For ALL organizational locations that will be contracted with Molina)
- ☐ Copy of CURRENT professional liability (or general, if no professional) insurance face sheet
  (For ALL organizational locations that will be contracted with Molina)
- ☐ Copy of recognized organizational accreditation certificate(s)
  (Recognized accrediting bodies specified in the organizational credentialing application)
- ☐ Copy of W-9 form(s) and the IRS Employer Identification Number letter
  (For ALL organizational locations that will be contracted with Molina)
- ☐ Copy of a State-issued Medicaid enrollment confirmation letter *(showing individual enrollment)*

If your organization is NOT accredited and is CMS certified, you must supply ONE of the following:

- ☐ Copy of the most recent CMS or State on-site survey results

OR

- ☐ Copy of the letter verifying approval of CMS participation and certification.

FACILITY INFORMATION FORM

Provide the following details ONLY in relation to your intended affiliation with Molina Healthcare of New Mexico. Attach any necessary addendums showing additional practice information (e.g., groups, addresses, etc.).

FACILITY INFORMATION (to be used for contracting w/ Molina Healthcare)**:**

Legal Name:	Primary TIN:
DBA Name:	Primary NPI:
Primary Specialty (w/ Molina Healthcare):	
Secondary Specialties (w/ Molina Healthcare):	
Will your organization use telemedicine services from New Mexico-based providers?: ☐ YES ☐ NO	Will your organization use telemedicine services from providers who practice from locations/sites outside of NM?: ☐ YES ☐ NO
Do you want your organization listed in Molina's Provider Directory?: ☐ YES ☐ NO	Molina requires electronic claims submission. Will you be capable of submitting claims electronically?: ☐ YES ☐ NO

PRIMARY PRACTICE INFORMATION (to be used for contracting w/ Molina Healthcare)**:**

Location Accredited *(if not solo)*: ☐ YES ☐ NO ☐ N/A		Accredited by *(if accredited)*:	
Age/Gender/Other Practice Limitations:			
Physical Street Address:		Suite/Floor:	
City:	State:	County:	ZIP:
Phone:	Fax:	E-mail:	

CONTRACTING CONTACT INFORMATION:

Contact Name:	Phone:	E-mail:

CREDENTIALING CONTACT INFORMATION:

Contact Name:	Phone:	E-mail: