

INSTRUCTIONS:

Please submit this completed form and the required attachments. Incomplete forms will be returned for completion prior to processing. Please return this form and all attachments to the location specified on your cover letter.

The following facility types can submit one form to cover all locations and a roster of all locations must be included:

- Atypical Providers
- Durable Medical Equipment Suppliers
- Federally Qualified Health Centers (FQHC)
- Indian Health Clinics
- Laboratories
- Physical Therapy/Occupational Therapy/Speech Therapy
- Radiology
- Rural Health Centers (RHC)
- Transportation Services
- Urgent Care

Facilities with multiple locations that share one license only need to complete one form.

All other facility types must complete a separate form for each location.

The information listed below should accompany the completed form:

- ✓ *Copies of current organizational or facility licenses/certifications/registrations*
- ✓ *A copy of your current (not expired) professional liability insurance face sheet*
- ✓ *A copy of the letter verifying approval of CMS participation (if applicable)*
- ✓ *If your organization is not accredited by a body listed in Section 4 of this form and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results.*
- ✓ *W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility (Only Page 1 of this form is needed: <http://www.irs.gov/pub/irs-pdf/fw9.pdf>)*

1. ORGANIZATION INFORMATION:
(Provide physical location information on the following page)

Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # <i>(primary)</i> :	Organization Medicaid # <i>(primary)</i> :
Organization TIN <i>(primary)</i> :	Organization NPI <i>(primary)</i> :
Credentialing Contact	Billing Address <i>(if different than Credentialing)</i>
Street Address: _____	Street Address: _____
Address Line 2: _____	Address Line 2: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Contact Name: _____	Contact Name: _____
Email: _____	Email: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

2. CURRENT PROFESSIONAL LIABILITY INSURANCE:
 Please check here if your facility is not required to carry **professional** liability insurance.

Current Carrier Name:	Policy Number:
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:



COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed with Molina Healthcare.
Complete a copy of sections 3 and 4 of this form for every location where information differs between locations.

3. PHYSICAL LOCATION INFORMATION:
(Include any additional information relevant to this location on a separate sheet)

Location DBA (if different than the Organization DBA)	
Other DBAs Previously Used (if under same ownership)	
Is this location Medicare Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this the primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location	State provider # (if applicable, LTC, etc.):
Street Address:	Is this location handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address Line 2: _____	
City: _____ State: _____ Zip: _____	
Phone: _____ Fax: _____	
Please list any languages spoken by office personnel:	
Practice Limitations (e.g., age, gender, etc.):	

Location State License(s) and/or State Registration(s) – (Attach a copy of all)

Please check here if this location is not required to be licensed, certified, or registered by a State agency.

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – (Attach a copy of all)

Please check here if this location holds no additional licenses, certificates, registrations, etc.

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

Specialty & Federal Taxonomy Code

Specialty & Federal Taxonomy Code

4. ACCREDITATION / CERTIFICATION (check all that apply):
 Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.

 Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.

Accreditation Organization	Date of Last Survey
<input type="checkbox"/> (CMS) Medicare Certification (<i>attach most recent survey and acceptance letter</i>)	
<input type="checkbox"/> (AAAH) Accreditation Association for Ambulatory Health Care	
<input type="checkbox"/> (ACHC) Accreditation Commission for Health Care	
<input type="checkbox"/> (AAAASF) American Association for Accreditation of Ambulatory Surgery Facilities	
<input type="checkbox"/> (AADE) American Association of Diabetes Educators	
<input type="checkbox"/> (AAHHS) Accreditation Association for Hospitals & Health Systems (AOA)	
<input type="checkbox"/> (ACR) American College of Radiologists	
<input type="checkbox"/> (CABC) Commission for the Accreditation of Birth Centers	
<input type="checkbox"/> (CARF) Commission on Accreditation of Rehabilitation Facilities	
<input type="checkbox"/> (CCAC) Continuing Care Accreditation Co	
<input type="checkbox"/> (CLIA) Clinical Laboratory Improvement Amendments	
<input type="checkbox"/> (COLA) Committee of Laboratory Accreditation	
<input type="checkbox"/> (CHAP) Community Health Accreditation Program	
<input type="checkbox"/> (COA) Council on Accreditation	
<input type="checkbox"/> (DNV) Det Norske Veritas – National Integrated Accreditation for Healthcare Organizations	
<input type="checkbox"/> (IAC) The Intersocietal Accreditation Commission	
<input type="checkbox"/> (IHS) Indian Health Services	
<input type="checkbox"/> (OSHA) Occupational Safety and Health Administration	
<input type="checkbox"/> (SAMHSA) Substance Abuse and Mental Health Services Administration	
<input type="checkbox"/> (TJC) The Joint Commission	