



Provider Contract Request Form

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 MHWIPProviderNetworkManagement@MolinaHealthcare.com or call (855) 326-5059 for assistance.

If you are adding providers to a participating group or PHO/PO, please submit a Provider Information Update Form to MHWIPProviderNetworkManagement@MolinaHealthcare.com.

PLEASE SELECT PROVIDER TYPE					
<input type="checkbox"/> Individual	<input type="checkbox"/> Medical Group	<input type="checkbox"/> ASC	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> FQHC	<input type="checkbox"/> RHC
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Home Health	<input type="checkbox"/> DME	<input type="checkbox"/> Other		

LINE OF BUSINESS					
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Marketplace			

CONTACT INFORMATION	
Requestor Name: _____	Requestor Phone: _____
Requestor Email: _____	Requestor Fax: _____

PROVIDER INFORMATION	
Legal Entity Name: _____	
Business/Service Address: _____ <small>(If additional locations, please attach roster.)</small>	Mailing address: _____ <small>(Contract will be emailed.)</small>
City, State, Zip: _____	City, State, ZIP: _____
Office Phone: _____	Contact Phone: _____
Office Fax: _____	Contact Fax: _____
Office Email: _____	Contact Email: _____

PROVIDER IDENTIFICATION	
Group Specialty: _____	Tax ID (TIN): _____
* Group Billing NPI(s): _____ <small>(* List all Group NPI(s) applicable to the corresponding Tax ID.)</small>	
Wisconsin Medicaid ID Number: _____	
Hospital Affiliation(s): _____	

If you are a professional practice that employs multiple providers, please provide information for all individual providers on a separate roster including provider name, NPI, locations (if multiple), specialty, PCP (yes or no), accepting new patients (yes or no), list in provider directory (yes or no). A roster template can be found at molinahealthcare.com/providers/wi/medicaid/forms/fuf.

Please note that completion of the above information is not confirmation of your participation status with Molina Healthcare of Wisconsin. Final contractual status is based upon your ability to meet credentialing standards and any additional contractual obligations. If you have any questions regarding completion of this form, email the Provider Network Management team at MHWIPProviderNetworkManagement@MolinaHealthcare.com