MOLINA HEALTHCARE

Contract Request Form (CRF)

(Please print legibly.)

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 fax number: 877-900-5655 Attn: Contracting Team or email form to: mhtcontractrequest@molinahealthcare.com

Please Select Provider Type

☐ Individual ☐ Group ☐ Ancillary ☐ Hospital ☐ SNF ☐ LTAC ☐ Urgent Care/ER

☐ Nursing Facility ☐ Assisted Living Facility ☐ ________________LTSS (*specify type)*

☐ Home Modification ☐ DME ☐ PT/OT/SP ☐ CORF/ORF ☐ Other (please specify)___________

☐ ***Check Here if Adding Provider to Existing Group*** ***(Please submit current group roster with request)***

Requestor Name: ______________________________ Requestor Phone: ______________________________

Requestor Email: ______________________________ Requestor Fax: ______________________________

Provider Name: ______________________________ Group Name: ______________________________

☐ ***Primary Care Provider designation***

Business/Service Address: ______________________ Mailing address: ______________________________
(If additional locations please attach roster) *(Contract will be emailed unless indicated here where to send)*

City, State, Zip: ______________________________ City, State, and Zip: ______________________________

Office Phone: ______________________________ Contact Phone: ______________________________

Office Fax: ______________________________ Contact Fax: ______________________________

Office Email: ______________________________ Contact Email: ______________________________

Specialty:______________________________ Taxonomy:______________________________

Tax ID: ______________________________ Bill Type: ☐ CMS1500 ☐ UB04 ☐ Both

Ind. NPI/API:______________________________ Group NPI/API:______________________________

Ind. TPI:______________________________ Group TPI:______________________________

Ind. Medicare*:______________________________ Group Medicare*:______________________________
*(*note: required for contracting)* *(*note: cannot create group contract if no group Medicare)*

Ind. CAQH: ______________________________ DADS Contract #:______________________________
(if applicable) *(if applicable)*

Date requested:______________________________

Once completed form is submitted, please allow 3-5 business days for contract packet to be mailed.
Included in the contract package will be an opportunity to provide us with more details about your office.

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