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 # *(primary)*:	Organization Medicaid # *(primary)*:
Organization TIN *(primary)*:	Organization NPI *(primary)*:
Credentialing Contact Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____	**Billing Address** *(if different than Credentialing)* Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____

2. CURRENT PROFESSIONAL LIABILTY 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 2 and 3 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? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location Street Address**:** Address Line 2**:** _____ City:_____State:_____Zip: _____ Phone:_____Fax: _____	State provider # *(if applicable, LTC, etc.)*: Is this location handicap accessible? ☐ **Yes** ☐ **No**
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**
☐ (CMS)	Medicare Certification *(attach most recent survey and acceptance letter)*	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care	
☐ (ACHC)	Accreditation Commission for Health Care	
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
☐ (AADE)	American Association of Diabetes Educators	
☐ (AAHHS)	Accreditation Association for Hospitals & Health Systems (AOA)	
☐ (ACR)	American College of Radiologists	
☐ (CABC)	Commission for the Accreditation of Birth Centers	
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities	
☐ (CCAC)	Continuing Care Accreditation Co	
☐ (CLIA)	Clinical Laboratory Improvement Amendments	
☐ (COLA)	Committee of Laboratory Accreditation	
☐ (CHAP)	Community Health Accreditation Program	
☐ (COA)	Council on Accreditation	
☐ (DNV)	Det Norske Veritas – National Integrated Accreditation for Healthcare Organizations	
☐ (IAC)	The Intersocietal Accreditation Commission	
☐ (HIS)	Indian Health Services	
☐ (OSHA)	Occupational Safety and Health Administration	
☐ SAMHSA)	Substance Abuse and Mental Health Services Administration	
☐ (TJC)	The Joint Commission	