ATTACHMENT C PROVIDER ROSTER

Please note the three sections of this form: 1. Practice Contact Information 2. Practice Name, Location and Important Information 3. Provider Details

Contract Entity Type ☐ Solo Practice ☐ Group Practice ☐ IPA ☐ FQHC/RHC

Practice Credentialing contact person:

Name: _____ Title: _____

Phone: _____ Email: _____

1. _____ _____ _____-_____
   Group Name Group NPI Group TIN
2. _____ _____ _____-_____
   Group Name Group NPI Group TIN
3. _____ _____ _____-_____
   Group Name Group NPI Group TIN

Practice Names and Locations Affiliated with Contract
(for Members' Provider Directory) - *Please list 'Same' if the Name is the same as the Group listed above.*

1. _____ _____
   Practice Name Address including Bldg, Suite #

   _____ _____
   City, State, Zip County

   _____ _____
   Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

2. _____ _____
   Practice Name Address including Bldg, Suite #

   _____ _____
   City, State, Zip County

   _____ _____
   Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

3. _____ _____
Practice Name Address including Bldg, Suite #

_____ _____
City, State, Zip County

_____ _____
Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

In Order for Providers to be Affiliated with Practice, these items must be included:

- o CAQH ID - current Attestation, current practice listed, authorize Molina access
- o Attach SCDHHS Enrollment Verification letter if recently applied for Medicaid ID
- o An incomplete package will delay or term the credentialing process

If the PCP box is checked, Provider will be credentialed, listed in Molina Directory and assigned members.

1. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): 1 2 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

2. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

3. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

4. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

5. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

If more space is needed to capture information, please print a copy of this roster and submit the copy with your Agreement for submission. Thank you!