Massachusetts Provider Contract Request Form

If you are **not** currently a contracted provider with Molina Healthcare and are interested in joining our network of quality health care providers, please email this completed form to SWHNetworkRequests@MolinaHealthCare.Com

Please note: In order for providers to contract with a Medicaid managed care plan, MassHealth requires **all providers** to be enrolled with Massachusetts Medicaid at both the practice/facility and individual provider levels, as applicable. In addition provider must be in practice for 2 plus years and have treated members age 65 plus.

If you are an individual provider joining a Molina contracted practice, please complete and submit a Provider Information Update Form (PIF). Click here for the form, or go https://www.molinahealthcare.com/providers/ma/swh/resources/forms.aspx.

If you are an individual leaving a contracted practice and now starting your own practice, please complete this form.

Please submit the following documentation:

- Copy of the most recent accreditation certificate/license(s) which includes the effective date and expiration date
- W-9 reflecting the appropriate Legal business name, signed and dated

Requestor Information:

Contact Name: _____ **Contact Phone:** _____ **Contact Email:** _____

PLEASE SELECT PROVIDER TYPE					
☐ Individual	☐ Multi-Specialty	☐ ASC	☐ Urgent Care	☐ FQHC/RHC	☐ Hospital
☐ Behavioral	☐ Home Health	☐ DME	☐ SNFs	☐ Other (specify)	

Provider Name/Legal Practice Name: _____

(for individual) First Name: _____ **Last Name:**_____ **CAQH ID#:** _____

Note: Please ensure the provider has completed and/or re-attested to the CAQH application and has authorized Molina Healthcare to access the CAQH record.

Practice Address: _____ **Suite#:** _____ **City:**_____ **State:** _____ **Zip:** _____

County(ies)/Community serviced: _____

(If you have additional physical locations, please attach a separate list including address, phone, contact name, TIN, and NPI.

Telephone:_____**Fax:**_____ **Email:** _____ **Website:**_____

Tax ID#: _____**Provider NPI #:** _____ **Billing NPI#** _____

Are you enrolled in Medicaid? ☐ **Yes** ☐ **No** **Are you enrolled in Medicare?** ☐ **Yes** ☐ **No** **Are you currently seeing our Members?** ☐ **Yes** ☐ **No**

Medicaid ID: _____ **Medicare ID:** _____ **Primary Taxonomy #:** _____

Are you ADA Compliant? ☐ **Yes** ☐ **No** **Offer Weekend/Late Appointment?** ☐ **Yes** ☐ **No** **Offer Telehealth:** ☐ **Yes** ☐ **No**

Contracting/Credentialing Contact:

Full Name:_____ **Telephone:** _____ **Email:** _____

Total Number of Practitioners part of the practice: _____

Are all Practitioners employed by the group? ☐ **Yes** ☐ **No**

If NO, please be advised that separate Provider Services Agreements will need to be completed for non-employed providers.

Primary Specialty: _____ Secondary Specialty: _____

Please provide additional information, such as services/modalities that you would like to include that would make your request unique for consideration:_____

_____

_____

_____

Please note: *that completion of the above information is not confirmation of your participation status with Molina Healthcare. This request is not a credentialing from. Final contractual status determination is based upon your ability to meet credentialing requirements and contractual obligations. Determination is subject to departmental review based on network needs and can be presented to a monthly contracting committee review. Please do not reach out for status until after 30 days of your submission. Within or after the 30 days, a member of the Contracting Team will reach out and if available can expect a decision.*