



# Ohio Dental Provider Contract Request Form

If you are not currently contracted with Molina Healthcare of Ohio and you are a dentist interested in joining our network of quality health care providers, or if you wish to add a line of business to your existing dental contract, please email this completed form to Molina Dental Services at [Denta.VisionDevelopment@MolinaHealthcare.com](mailto:Denta.VisionDevelopment@MolinaHealthcare.com).

**Please note:** In order for providers to contract with a Medicaid managed care plan, the Ohio Department of Medicaid requires **all providers** to be enrolled with Ohio Medicaid at both the practice/facility and individual provider levels, as applicable.

**If you are an individual provider joining a contracted practice, please do not complete or submit this form. Please complete and submit a Provider Information Update Form (PIF). [Click here](#) to find the form, or go to [www.MolinaHealthcare.com/OhioProviders](http://www.MolinaHealthcare.com/OhioProviders), click on the “Forms” tab and look under the “Contracted Providers Making Changes” section. Once you have completed the PIF, please email the form to [MDVSPIM@MolinaHealthcare.com](mailto:MDVSPIM@MolinaHealthcare.com).**

Practice/Facility Name: \_\_\_\_\_

Practice/Facility Ohio Medicaid ID: \_\_\_\_\_ Practice/Facility Tax ID Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Office Location (if different from mailing address): \_\_\_\_\_

Specialty/Provider Type: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_

County: \_\_\_\_\_ Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

**If you are a professional practice that employs multiple providers, please provide information for all individual providers in the table below or on a separate sheet (excludes ancillary providers):**

| Individual Provider Name | Provider Type/Specialty | Individual Medicaid ID | Individual Medicare ID | Individual NPI |
|--------------------------|-------------------------|------------------------|------------------------|----------------|
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Are all providers employed by the group?  Yes or  No

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

Any additional information you would like to include relative to your request:

You will be contacted by a member of the Provider Information Management (PIM) team within 30 days of submitting this form. If you have any questions regarding completion of this form, email PIM at [MDVSPIM@MolinaHealthcare.com](mailto:MDVSPIM@MolinaHealthcare.com).

*Please note that completion of the above information is not confirmation of your participation status with Molina Healthcare of Ohio. Final contractual status is based upon your ability to meet credentialing requirements and contractual obligations.*