Molina Healthcare of New Mexico, Inc.

APPLICATION CHECKLIST & INSTRUCTIONS

Please complete the below form and submit it to your Molina Healthcare representative.

Note: Using the CAQH Universal Credentialing Data Source does not constitute applying for participation with any health care organization. Contact your Molina Healthcare representative directly regarding contracting. Please make sure that your CAQH information is current & complete. Failure to supply all information listed below or to complete all forms entirely will prevent initiation of the credentialing process and will cause delays in the contracting process.

If you already participate in CAQH:
* Molina must have access to a completed application attested to w/in the past 120 days.
* You must give Molina Healthcare authorization to use your CAQH application.
* Failure to do **ALL** these steps will prevent initiation of the credentialing process.

If you would like to participate in CAQH:
* Submit the information on the attached Provider Information Form to your Molina representative
* Molina will submit your information to CAQH to create your account and obtain a CAQH ID.
* Here are the steps to get started: https://upd.caqh.org/OAS/GettingStarted.aspx
* You may access the general CAQH website at https://upd.caqh.org/oas.
* You must complete the CAQH application in its entirety and give Molina authorization to use it.
* You must notify your Molina representative once your application is complete and available.
* Failure to do ALL these steps will prevent initiation of the credentialing process.

The following documents are required to complete your credentialing.

You must always include these documents:

☐ Completed Practitioner Information Form (attached, pg. 2)
(Failure to complete in its entirety for each practitioner to be credentialed will prevent initiation of credentialing)

☐ Completed Ownership/Controlling Interest Disclosure Form (Failure to complete in its entirety for each practitioner to be credentialed will prevent initiation of credentialing)

☐ For Physician Assistants ONLY: A copy of the first two pages of your supervising physician agreement
http://www.nmmb.state.nm.us/pdffiles/SupervisingPhysicianSR.pdf

W9 and IRS letter for Tax Identification Number (TIN)

If you do not utilize CAQH, you must always include these documents or credentialing cannot be initiated:

☐ Complete credentialing application w/ Molina specific attestation (signed within 120 days)
(Must be completed for each practitioner to be credentialed & attested within the past 120 days)

☐ Copy of curriculum vitae or resume
(Only required if application references the CV/Resume or has date gaps)

☐ Copy of W-9 form(s)
(for ALL practice groups that will be contracted with Molina for each practitioner)

☐ Copy of CURRENT professional liability malpractice insurance face sheet
(for ALL practice groups that will be contracted with Molina for each practitioner)

☐ Copy of certificates for conducting x-ray and/or laboratory service(s)
(for ALL practice groups that will be contracted with Molina for each practitioner)

☐ Copy of a State-issued Medicaid enrollment confirmation letter (showing organization enrollment)

MOLINA HEALTHCARE

PRACTITIONER INFORMATION FORM

Provide the following details ONLY in relation to your intended affiliation with Molina Healthcare of New Mexico.
Attach any necessary addendums showing additional practice information (e.g., groups, addresses, etc.)

PRACTITIONER INFORMATION (to be used for contracting w/ Molina Healthcare):

Start/Hire Date:	

Status w/CAQH: ☐ I am participating ☐ I would like to participate ☐ I do not want to participate	CAQH ID Number: (If already participating) Individual NPI:

Last Name:	First Name:	Middle Initial:

Provider Type MD, PT, etc.):	Date of Birth:	Last 4 digits of SSN:

Directory Category ☐**PCP** ☐ **Specialist** ☐**Allied Ancillary** **Provider Directory**: ☐ Yes ☐ No **Accepting New Members**: ☐ Yes ☐ No **Prescriptive Authority (RX)**: ☐ Yes ☐ No	Molina requires electronic claims submission. Will you be able to submit claims electronically? ☐ Yes ☐ No

Providing telemedicine services to Molina members from: ☐ Within NM ☐ Outside of NM

Primary Specialty (w/ Molina Healthcare):

Secondary Specialties (w/Molina Healthcare):

Supervising Provider Name (If applicable):

PRIMARY PRACTICE INFORMATION (to be used for contracting w/ Molina Healthcare):

Practice Type: ☐ Solo Practice ☐ Group/Clinic Practice ☐Hospital Employee	Facility Accredited: ☐ Yes ☐ No ☐ N/A	Accredited with (if accredited):
Group/Facility Name (If not solo):		Group NPI:
Age/Gender/Other Practice Limitation:		Tax ID # (TIN):
Physical Street Address:		Suite/Floor:

City:	State:	County:	Zip:
Phone:	Fax:	E-mail:	

Office Hours:	Monday:From	to	Thursday:From	to
	Tuesday:From	to	Friday: From	to
	Wednesday:From	to	Saturday:From Sunday: From	to to

Mailing Address:

City:	State:	Zip:
Credentialing Contact Name:	Phone:	E-mail: