MOLINA HEALTHCARE
Your Extended Family.

# Guide to Provider Forms

| ACTION | YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED |
|---|---|
| Add a Provider to the group | • PIF – Complete Section A, Section N* and Section O<br>* Section N can be copied when adding multiple providers<br>• Attachment A (Primary Care Providers, Specialists and Ancillary Providers)<br>• Attachment B (Hospital Services)<br>• CAQH (if applicable) |
| Individual: Change or add a service location | • PIF – Complete Section A, Section H and Section O<br>• Attachment A (Primary Care Providers, Specialists and Ancillary Providers)<br>• Attachment B (Hospital Services) |
| Change Phone/Fax | • PIF – Complete Section A, Section F and Section O |
| Change the Pay-To/ Billing Address | • PIF – Complete Section A and Section I<br>• W-9<br>• Sample Claim Form (de-identified) |
| Group: Change or add a service location | • PIF – Complete Section A, Section G and Section O<br>• Attachment A (Primary Care Providers, Specialists and Ancillary Providers)<br>• Attachment B (Hospital Services)<br>• ADA Attestation Form |

| | |
|---|---|
| Add a new group to the same Tax Identification Number (TIN) | • PIF – Complete Section A<br>• W-9<br>• Attachment A (Primary Care Providers, Specialists and Ancillary Providers)<br>• Attachment B (Hospital Services)<br>• Sample Claim Form (de-identified) |
| Change Group Name Only | • PIF – Complete Section A and Section D<br>• Attachment A (Primary Care Providers, Specialists and Ancillary Providers) with new group name<br>• Attachment B (Hospital Services) with new group name<br>• Sample Claim Form (de-identified)<br>• W-9 |
| Change TIN only | • PIF – Complete Section A and Section B<br>• W-9<br>• Sample Claim Form (de-indentified) |
| Individual Name Change | • PIF – Complete Section A and Section E<br>• Attachment A (Primary Care Providers, Specialists and Ancillary Providers)<br>• Attachment B (Hospital Services) |
| Terming a provider | • See Section J for instructions |
| Provider Directory Update | • PIF – Complete Section A and Section L |
| Panel Update | • PIF – Complete Section A and Section K |
| Hospital Affiliations Update | • PIF – Complete Section A and Section M |
| Group/Individual NPI or Medicaid ID Change/Addition | • PIF – Complete Section A and Section C |

| FORMS: | FORM USAGE: |
|---|---|
| Provider Information Update Form (PIF) | This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare. |
| Attachment A | This form is used for all Primary Care Providers (PCPs), Specialists and Ancillary Providers. |
| Attachment B | This form is used for all hospitals and hospital services. |
| W-9 | This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name, and Tax ID when received with a PIF. |
| ADA Attestation Form | Providers use this form to attest to their compliance with American Disabilities Act (ADA) requirements for each physical service location. |
| **Credentialing - Individual Providers** | **YOU WILL NEED TO…** |
| If you have a CAQH number | Complete CAQH Provider Data Form. You also need to update and give Molina Healthcare permission to review. Visit the website at http://www.caqh.org. |
| If you do not have a CAQH number | Go to http://www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review. |
| **Credentialing - Facilities and Other Providers** | **YOU WILL NEED TO …** |
| Including Hospitals, Ambulatory Surgical Centers, Home Health Agencies, Durable Medical Equipment (DME) Suppliers, SNFs, Urgent Care Centers, and Retail Clinics | Print, complete, fax, email or mail the Ohio Department of Insurance Standardized Credentialing Form Part B (Molina Healthcare refers to this as "HDO"). This form can also be found at Quicklinks located at http://www.insurance.ohio.gov.<br><br>Molina Healthcare of Ohio<br>Attention: PIM<br>P.O. Box 349020<br>Columbus, OH 43234-9904<br><br>Fax: (866) 713-1893<br><br>Email: MHOProviderUpdates@MolinaHealthCare.com |
| **CONTACT INFORMATION** | If you have additional questions please contact Molina Healthcare's Provider Services department at (855) 322-4079 between the hours of 8 a.m. to 5 p.m. EST, Monday through Friday. |

MOLINA HEALTHCARE
Your Extended Family.

# Provider Information Update Form (PIF)

Submission Date _____/_____/_____

This form and the associated documentation are required to notify Molina Healthcare of Ohio of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at www.MolinaHealthcare.com.

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Type of Group/Provider (Select all that apply):

☐ PCP ☐ Specialist ☐ Dental ☐ BH - Private Practice ☐ BH - CMHC/SUD

☐ Ancillary ☐ LTSS ☐ FQHC/RHC ☐ QFPP/Title X ☐ Urgent Care ☐ Hospital

**CMHC/SUD Agencies Only: For any entity/organization-level updates, please use this form. All updates to employed rendering providers at a CMHC/SUD must be made through the Ohio Department of Medicaid/MITS System.**

**All Providers: If changing your Group/Practice Name and Tax ID Number, an Amendment is required. However, if changing the Group/Practice Name and Tax ID due to an ownership change, a new contract may be required. Please contact Molina Healthcare Provider Services at (855) 322-4079. A representative will be available to assist you Monday through Friday, 8 a.m. - 5 p.m. EST.**

## SECTION A

**Current Group/Practice Information** (*All fields in this section are required*)

Group/Practice Name: _____

Group/Practice Tax ID: _____ Group/Practice Medicaid #: _____

Group/Practice NPI #: _____ Contact Number: _____

Email Address: _____ Contact Name: _____

Tax Exempt ☐ Yes ☐ No

*Return to first page.*

## SECTION B

**Tax ID Number Change** Effective Date _____/_____/_____

Previous Tax ID Number: _____ New Tax ID Number: _____

*Return to first page.*

## SECTION C

**Group/Individual NPI or Medicaid ID Change/Addition** Effective Date _____/_____/_____

☐ **Group NPI** ☐ **Individual NPI**

(If adding an NPI, do not fill out "Previous NPI" line.)

Group/Individual Name: _____

Previous NPI: _____

New NPI: _____

☐ **Group Medicaid ID** ☐ **Individual Medicaid ID**

(If adding a Medicaid ID, do not fill out "Previous Medicaid ID" line.)

Previous Medicaid ID: _____

New Medcaid ID: _____

*Return to first page.*

## SECTION D

**Group/Practice Name Change** Effective Date _____/_____/_____

Previous Group/Practice Name: _____ Medicaid #: _____

New Group/Practice Name: _____ Medicaid #: _____

*Return to first page.*

# OTHER CHANGES

## SECTION E

**Individual Name Change** Effective Date _____/_____/_____

Previous Name: _____ New Name: _____

*Return to first page.*

## SECTION F

**Change Phone/Fax** Effective Date _____/_____/_____

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

*Return to first page.*

## Section G (Group)

☐ **Add a Service Location** Effective Date _____/_____/_____

☐ **Change a Service Location**

Is location closing: Y ☐ N ☐

Please complete the ADA Attestation Form for all new Service Locations.

| **Previous Address** | **New Address** |
|---|---|
| Service Location Name:_____ | Service Location Name:_____ |
| Address 1: _____ | Address 1: _____ |
| Address 2: _____ | Address 2: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Phone Number: _____ | Phone Number: _____ |
| Fax Number: _____ | Fax Number: _____ |
| Email: _____ | Email: _____ |

*Return to first page.*

## Section H (Individual)

☐ **Add a Provider to a Service Location** Effective Date _____/_____/_____

☐ **Change Service location for a Provider**

| **Previous Address** | **New Address** |
|---|---|
| Service Location Name:_____ | Service Location Name:_____ |
| Address 1: _____ | Address 1: _____ |
| Address 2: _____ | Address 2: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Phone Number: _____ | Phone Number: _____ |
| Fax Number: _____ | Fax Number: _____ |
| Email: _____ | Email: _____ |

*Return to first page.*

## SECTION I

**Billing Address Change** Effective Date _____/_____/_____

| Previous Billing Information | New Billing Information |
|---|---|
| Billing Contact: _____ | Billing Contact: _____ |
| Address 1: _____ | Address 1: _____ |
| Address 2: _____ | Address 2: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Phone Number: _____ | Phone Number: _____ |
| Fax Number: _____ | Fax Number: _____ |

- Is this a Notice Address Change? ☐ No ☐ Yes

*The Notice Address is the particular party's address for delivery or mailing of notice purposes.*

*Return to first page.*

## SECTION J

**Terminating a Provider**

A termination letter is required on company letterhead and must include the following: Group Name, Group Tax ID, Group NPI, name of the provider to be termed, Provider NPI, effective date of termination, reason for termination and address of practice location(s). If terming provider is a PCP, include name of provider that will assume patient panel.

*Return to first page.*

## SECTION K

**Panel Update** Effective Date _____/_____/_____

☐ Existing Patients ☐ Only Close Panel to all Members ☐ Open Panel

Reason: *(Required)* _____

*Return to first page.*

## SECTION L

**Provider Directory Update** Effective Date _____/_____/_____

☐ Include in Provider Directory ☐ Exclude from Provider Directory

Reason: *(Required)* _____

*Return to first page.*

## SECTION M

**Hospital Affiliations Update** Effective Date _____/_____/_____

☐ Add Hospital Affiliation(s) ☐ Remove Hospital Affiliation(s)

Names of Hospital(s): _____

*Return to first page.*

## SECTION N

**Provider Joining a Group/Practice** Effective Date _____/_____/_____ Locum Tenen: ☐ Y ☐ N

Provider Name (Last, First, MI):_____

Provider Type (MD, DO, DC, DDS, DPM, etc): _____ Date of Birth: _____

Last Four Digits of Social Security #: _____ Provider Ethnicity:

☐ African American ☐ Caucasian

☐ Asian/Pacific Islander ☐ Hispanic

☐ Alaskan/American Indian ☐ Other

Individual Provider NPI Number: _____ CAQH Provider Number: _____

| For Nurse Practioners, Physician Assistants and Nurse Midwives only: | Supervising Physician Name & Degree | Supervising Physician Specialty: |
|---|---|---|

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

OH Medicaid Number: _____ OH Medicare Number: _____
(Provider must have an active Medicaid Number)

Specialty: _____ Secondary Specialty: _____

Applying as: ☐ PCP ☐ Specialist ☐ Hospitalist ☐ Other

For Behavioral Health Providers: Are you individually accessible by appointment? ☐ Yes ☐ No

Board Certified: ☐ Yes ☐ No Effective Date _____/_____/_____ Expiration Date _____/_____/_____

Certification Board: _____

Group/Practice Name: _____

Group/Practice Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

*Return to first page.*

## Section 0

**Office Hours**

| | From | To |
|---|---|---|
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

*Return to first page.*

If you have any questions, visit our website at www.MolinaHealthcare.com or call Provider Services at (855) 322-4079. Representatives are available to assist you Monday through Friday from 8 a.m. to 5 p.m.

**Please mail, fax or email this form and supporting documentation to:**

Molina Healthcare of Ohio
Attn: PIM
P.O. Box 349020 Columbus, OH 43234-9904
Fax (866) 713-1893
MHOProviderUpdates@MolinaHealthcare.com

*Return to first page.*

Ohio Department of Medicaid

# MANAGED CARE ENTITY (MCE) – GROUP PROVIDER AFFILIATIONS – ATTACHMENT A

| | |
|---|---|
| **Provider Group Name** | **MCE Name**<br>Molina Healthcare of Ohio, Inc. |
| **Group Tax ID Number** | **Group NPI*** |
| **Group Medicaid ID*** | |

***Please submit a separate Attachment A for any given Group/Location NPI and/or Group Medicaid ID.**

(Groups should provide Group name, NPI and Tax ID Number above and individual practitioner NPI under "Provider NPI" below.)
(Ancillary providers are not required to list employees on this attachment. Ancillary, Urgent Care, FQHC and RHC providers: List each service location.)

| Last | First | MI | Spec | Service Location (Name and Street Address) | Provider Medicaid ID | Provider NPI | Capacity (PCP only) |
|---|---|---|---|---|---|---|---|
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*MCE acknowledges changes on the date received. Effective Date will be determined by the MCE. Each rendering provider's name must be listed. "Capacity" represents the maximum number of the MCE's Medicaid members primary care providers (PCP) agree to serve. Please indicate a numeric capacity value instead of "unlimited" or similar response. For any given PCP, total capacity must not exceed 2,000 across all locations. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3).*

Return to first page.

# MANAGED CARE ENTITY (MCE) – HOSPITAL SERVICES ATTACHMENT B

The provider must complete a copy of this form for each hospital covered by the terms and conditions of this addendum. If multiple pages are used, the pages must be numbered sequentially on every page *(e.g., 1 of 3, 2 of 3, and 3 of 3)* and the signature block must be included on each page. MCE acknowledges changes on the date received. Effective Date will be determined by the MCE.

**Molina Healthcare of Ohio, Inc.**

## Hospital Information

| Hospital Name | | | | |
|---|---|---|---|---|
| Address | City | State | Zip | County |
| Tax ID Number | NPI | Secondary NPI | | |

1. Hospital Services Categories

Please check the applicable line for each category of service the above-named hospital covers.

| | | |
|---|---|---|
| ☐ Surgical Services | ☐ Neonatal Intensive Care - Level 3 | ☐ Special Care |
| ☐ Pediatric Surgical Services | ☐ Adult Intensive Care | ☐ Outpatient Psychiatric Services |
| ☐ Obstetrical Services | ☐ Midwife Services | ☐ Practitioner Services |
| ☐ Nursery Services | ☐ Outpatient Surgery | ☐ Other *(Please specify)* |
| ☐ Nursery Services Level 1 & 2 | ☐ Pediatric Intensive Care | |

2. Hospital does not provide the following hospital service(s) because of an objection on moral or religious grounds. List services:

*Return to first page.*

MOLINA HEALTHCARE

MyCareOhio
Connecting Medicare + Medicaid

**Please complete the following attestation for each provider service location and return it with your signed contract:**

**Provider Name:** _____ **Tax ID #or SSN:** _____

**Address:** _____ **Phone:** _____

**Email Address:** _____

The Americans with Disabilities Act (ADA) and Ohio Administrative Code (OAC) 3781.111 require providers make reasonable access and accommodations for all persons with disabilities. Molina is providing you with the opportunity to self-attest to the below ADA standards in order to verify core elements of ADA compliance for the MyCare Ohio program.

**If you are not an office-based provider, please check here and proceed to the signature section below:** ☐

**If you are an office-based provider, please check the applicable box next to each standard below and have the designated representative sign and return the attestation to Molina Healthcare.**

| ADA STANDARDS | YES | NO |
|---|---|---|
| Building has handicap designated parking. Parking spaces are accessible with ramps and curb cutouts between the parking lot, office, and at drop off locations. | | |
| Building has automatic entry option or alternative access method. | | |
| Building has elevator for public use (if building is multi-leveled). Elevator has enough room for the wheelchair and/or scooter to maneuver. | | |
| Restroom is equipped with large stall and safety bars or other reasonable accommodations. | | |
| Waiting room (including furniture) can accommodate patients with physical and non-physical disabilities. The reception and waiting areas have enough room for a wheelchair and/or scooter to maneuver and turn around. | | |
| At least one exam room can accommodate patients with physical and non-physical disabilities. | | |
| Signage and way finding is clear (e.g. color, symbol signage, and braille). | | |
| Doors to access building, office, and patient rooms are at least 32 inches wide. | | |
| The exam table moves up and down to make it easier to get on and off whether standing or using a wheelchair or scooter. | | |
| Diagnostic equipment can accommodate patients with disabilities. | | |
| The scale is able to accommodate a wheelchair or scooter. | | |

Provider service locations that attest to being ADA compliant or have received an in-office assessment and determined to be ADA compliant will be published as such in the Molina MyCare Ohio Provider Directory.

**I attest to the best of my knowledge that the above information is true, accurate and complete.**

Name: _____ Signature: _____

Title: _____ Date: _____

If you have any questions or concerns, please contact Molina Healthcare Provider Relations at (855) 322-4079. Thank you for your prompt response.