

Molina Complete Care ORGANIZATION PROVIDER APPLICATION

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable.

Complete entire application for primary site and Pages 6-7 only for additional locations.

- For entities with more than 15 locations, please complete this single application for one location, and contact Molina at MCCVA-Provider@molinahealthcare.com to request a spreadsheet template to expedite credentialing of your additional locations.
- Current copies of all supporting documents must be submitted with this application (licenses, insurance certificates, accreditation/certification/site visit reports, etc.) as referenced throughout the application.

Return this application by: E-Mail: MCCVA-Provider@molinahealthcare.com Fax: 888-656-5098 or Mail: Molina Complete Care, Provider Network Dept, 3829 Gaskins Road, Richmond, VA 23233

	SECTION A -	CORPORATE ENTITY	/ MAIN	SITE		
MAIN SITE IDENTIFYING INFORMATION	V					
Legal Name:				TIN Number:		
Other name(s) organization is known by (or	d/b/a):					
Website Address If your agency does not have a website, list						
If the organization is a subsidiary of, in partidentify the entity by name below:		otherwise administrativ	ely or org	ganizationally lin	ked w	rith a health system, please
Name of entity:						
name or emity.						
MAILING ADDRESS						
Mailing Address:						
City:	Cou	nty:		State:		Zip:
Contact Person (for credentialing						
correspondence):				Tit	le:	
Telephone: ()	Fax: ()		Email:		
BILLING INFORMATION						
Billing Legal Name:				Billing TIN N	lumbe	er:
Billing Address:						
City:	County:		State:		Zi	p:
Billing Contact Person:	,		Title:		ı	
Tolophonou()	Fav. /		- Fmaile			



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QUALITY (OF CARE												
	icility have a Polic ient Self Determi		lure ac	ddressing A	dvanced Dir	ectives	in acco	rdance wi	ith the			YES	□ NO
Does this fa	cility have a qual	ity improvem	ent pl	an?								YES	□NO
Does this fa	cility have a patie	ent satisfaction	on surv	ey process	;?							YES	□NO
Does each s	service location fo	ollow the poli	cies ar	nd procedu	res as define	ed by th	ne facilit	ty's prima	ry servi	ce location?		YES	□NO
				SE	CTION B -	SERVIO	CE LOC	ATION					
SPECIFIC S	SERVICE DELIVE	RY LOCATION	ON										
Location Na	ame:												
Street Addr	ess (No P.O. Box	please):											
City:			(County:				State:			Zip:		
Telephone:	()		ı	Fax: ()			Appoint Telepho		()			
Is this locat	ion physically acc	essible for pa	itients	and visitor	rs with disab	ilities?			,	/ES			NO
Does this lo	ocation have tele	communicat	ions fo	or the deaf	capability?				,	/ES			NO
	ion located with								,	/ES			NO
Indica	te business hours	s:											
В	usiness Hours:	MON 1	ΓUE	WED	THU	FRI	SAT	SUN	N				
S	tart Time:												
E	nd Time:								_				
В	y Appointment]				
AFTER HO	URS ACCESSIB	ILITY FOR P	ATIEN	ITS IN TR	EATMENT								
☐ An	swering Machine			Answering	Service		B	Beeper			Not Avai	lable	
After Hours	Telephone:	()								l			
	NFORMATION - only those that	•		•	on For Ma	odicaro	nlage	a provida	tha In	nationt cul	h provido	r ID nur	mbar (i a
	where applicat						-	-			-		
STATE	-	ТҮРЕ		NU	JMBER		_	LICEN	NSING B	ODY		EXF	PIRATION DATE
1.													
2.													
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This document is the proprietary information of Molina Healthcare, Inc., and its affiliates and the contents contained herein are confidential.



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CERTIFICATIONS/MEMBERS	SHIPS/PROV	IDER IDENTIFIERS – pleas	e submit co	pies	as applicable.		
CERTIFICATIO	N/MEMBER	RSHIPS	N	JMBE	ER EXPIRATION D	ATE	
Accept Medicare Assignments	?	Yes No					
Accept Medicaid Assignments	?	Yes No					
National Provider Identifier (N	PI):	☐ Yes ☐ No			N/A		
CLIA Certification?		☐ Yes ☐ No					
Enter additional certifications:							
BFD COUNTS – Please provi	de the numb	per of beds, in each catego	rv. Please lie	st only	y those that apply to this service location		
ТҮРЕ	NUMBER	ТҮРЕ	NUMBER		ТҮРЕ	NUMBER	
Coronary Care Unit (CCU)		Long Term Care (LTC)		Res	idential Treatment-Mental Health		
Crisis Stabilization Unit		Medical-Surgical		Res	idential Treatment-Substance Abuse		
Inpatient Mental Health		Medicare Certified Beds		Skil	led Nursing Facility (SNF)		
Inpatient Substance Abuse		Neonatal ICU (NICU)		Sur	gical ICU		
Intensive Care Unit (ICU)		Pediatric ICU (PICU)		Oth	ner (List):		
ACCREDITATION INFORMA	ΓΙΟΝ - Pleas	e include copy of current	accreditati	on do	ocumentation.		
					levels of care at this service location.		
ACCREDITING BODY	EXP DATE	ACCREDITING BODY	EXP DATE ACC		ACCREDITING BODY	EXP DATE	
TJC		CARF			HFAP/AOA		
AAAASF		CCAC			UCAOA		
AAAHC		СНАР			OTHER (LIST):		
AAUCM		COA			NONE (NON-ACCREDITED)		
ACHC		DNV/NIAHO					
INSURANCE INFORMATION							
Please also submit copy of		overage, for verification, f	or both ge	neral	and professional liability.		
	SIONAL LIABIL				GENERAL LIABILITY		
☐ Independent Carrier ☐	Self-Insured	State Tort Liability Act	☐ Indepen	ident (Carrier Self-Insured State Tort	Liability Act	
Current Carrier Name:			Current Ca	arrier	Name:		
Policy Number:			Policy Nur	nber:			
Policy Effective Date:			Policy Effe	ctive	Date:		
Policy Expiration Date:			Policy Exp	iratio	n Date:		
Per Occurrence Limit:			Per Occur	rence	e Limit:		
Aggregate Limit:			Aggregate Limit:				



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SERVICE LOCATION: Provider Designation. Please check all that apply for this specific location only. Please also submit copy of insurance coverage, for verification, for both general and professional liability.									
Ty	уре	Description	Т	уре	Description				
Г	04	Health Department		14	Nursing Facility (Intermediate	Skille	rd)		
	05	Hospice		16	Outpatient Rehabilitation (PT OT	□ST)			
	06								
	07	07 Outpatient Mental Health – Traditional Services							
	08	Addiction, Recovery, & Treatment Services (ARTS) 19 Home Health							
	09	Community MH Rehabilitative Services (CMHRS)		20	Laboratory				
] 10	Hospital - Psychiatric		26	Federally Qualified Health Center (FQHC)				
] 11	Hospital – General (Pediatric)		27	Community Services Board (CSB)				
	12	Hospital – Physical Rehabilitation		28	Rural Health Clinic (RHC)				
	13	Urgent Care		24	Other (please describe):				
		DISCLOSURE QUESTIONS: PLEASE PROVIDE SUP	PO	RTING	DOCUMENTATION FOR ANY "YES" ANS	WERS.			
		e organization or program or members of the organization thin the last five (5) years?	n's/	progra	m's staff been named in any malpractice	☐ YES	□ NO		
		e organization or program or any of the organization's or ρ non-renewed, restricted or special rated within the last firm				☐ YES	□ NO		
C 1 Has any government agency investigated suspended revoked or taken any other action against the						□ NO			
	2. At any time, has any license, specialty board certification or eligibility been revoked, reduced, denied, or suspended by the issuing entity or voluntarily given up by the organization or program or members of the organization's or program's staff, within the last five (5) years or are any actions which could possibly lead to such actions now under way?								
		e organization or program or members of the organization nem within the last five (5) years or are there any legal acti			, ,	☐ YES	□ NO		
		e organization or program or members of the organization civing payment under the Medicare and/or Medicaid Progr			·	☐ YES	□ NO		
0	thers or	time, have any memberships in a professional organizatio voluntarily given up by the organization or program or me ve (5) years or are there any actions that may lead to such	emb	ers of	the organization or program's staff, within	☐ YES	□ NO		
SI		e organization or program or members of the organization d from membership in a professional association for violatears?			•	☐ YES	□ NO		



Molina Complete Care ORGANIZATION PROVIDER APPLICATION

SECTION C – DECLARATIONS AND CONSENT

The Applicant hereby warrants and represents that all information supplied to Molina Healthcare, Inc., including, but not limited to, licensure, insurance and malpractice history, is true, accurate, and complete. The Applicant further understands that any information entered in this document by Applicant which subsequently is found to be false could result in removal from the network and/or termination of any agreement with Molina and/or its affiliated companies (Molina). The Applicant agrees to maintain professional and general liability coverage as stated in this document.

The Applicant grants permission and consent for Molina, and/or its designee, to obtain and verify information contained on the application and consents to the release by any person, organization, or other entity to Molina, and /or its designee, of all information that may be reasonably relevant to an evaluation of, including, but not limited to, the Organization's ability to render clinical services, character and moral and ethical qualifications. The Applicant expressly waives any privilege, confidentiality right or privacy right to which the Organization may be entitled. The Applicant agrees to hold harmless any such person, organization or other entity from any cause of action based on the release of such information, in good faith, to Molina and /or its designee pursuant to this consent. The Applicant releases Molina and its designees from any liability for any reports, records, recommendations, claims information and claims history, or any other information related to the Organization that are provided to Molina or its designee by a third party, including otherwise privileged and confidential information given in good faith and related to the credentialing process. The Organization further understands that participation as a provider for Molina is dependent upon successful completion of the credentialing process. A photocopy of this authorization shall be deemed equivalent to the original.

Applicants serving Medicaid/Medicare population(s): Applicant agrees to comply with applicable state and federal regulations, rules, policies, and procedures relating to servicing Medicaid/Medicare members.

I certify that I am authorized to make the above warranties, representations, authorizations and releases on behalf of this provider organization and to sign this application on behalf of this organization.

Name of Provider Organization (Please print)	Name of Authorized Representative (<i>Please print</i>)
Date	Signature of Authorized Representative



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ADDITIONAL SERVICE LOCATION SUPPLEMENT: Submit one copy for each additional service location.

			SECTION A -	- CORPORA	AIE ENIII	/ / MAIN S	SIIE			
MAIN SIT	E IDENTIFYING IN	NFORMATIO	ı							
Legal Name	e:						TIN Num	ıber:		
			SECTION B -	- DEMOGR	APHIC INF	ORMATIC	ON			
MAILING A	ADDRESS: 🗌 SA	ME AS CORPO	RATE ENTITY	SAME AS SI	ERVICE ADE	DRESS				
BILLING A	DDRESS: 🗌 SAN	IE AS CORPOR	ATE ENTITY	SAME AS SEI	RVICE ADDI	RESS				
SPECIFIC S	SERVICE DELIVER	Y LOCATION								
Location Na	ame:									
Street Addr	ress (No P.O. Box pl	ease):								
City:			County:			State:			Zip:	
Telephone:	()		Fax: ()		Appointm Telephone)		
Is this locat	ion physically acces	ssible for patier	ts and visitors w	vith disabilitie	es?		YES			NO
Does this lo	ocation have teleco	ommunications	for the deaf ca	pability?			YES			NO
Is this locat	tion located within	one block of a	public transpor	tation stop?			YES			NO
Indica	te business hours:									
В	Business Hours:	MON TUE	WED	THU FRI	I SAT	SUN				
S	tart Time:		· <u></u> -							
	nd Time: By Appointment									
_	, , , , , , , , , , , , , , , , , , ,									
AFTER HO	OURS ACCESSIBILI	ITY FOR PATI	ENTS IN TREAT	TMENT						
☐ Ar	nswering Machine		Answering Ser	vice		Beeper			Not Avail	able
After Hours	Telephone: (()								
LICENSE IN	NFORMATION – p	olease submit	copies.							
	only those that appl Please do not ente) number (i	.e., "99S999") where
STATE	ТУ		NUME			-	ING BODY	-		EXPIRATION DATE
1.										
2.										
3.										



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CERTIFIC	CATIONS/MEMBERS	HIPS/PRO	VIDER IDENT	TFIERS – pl	iease s	ubmit co	pies	as applicable.			
	CERTIFICATIO	N/MEMBE	RSHIPS			NU	MBE	ER EXPIRATION	DATE		
Accept M	ledicare Assignments	?	☐ Yes	☐ No							
	ledicaid Assignments?		☐ Yes	☐ No							
	Provider Identifier (N		Yes	☐ No				N/A			
CLIA Cert		/ -	Yes	☐ No				.,,			
	ditional certifications:							L			
Litter add	ational certifications.										
BED COL	JNTS – Please provid	de the num	ber of beds,	in each cat	egory.	Please lis	st on	nly those that apply to this service.			
	ТҮРЕ	NUMBER		ТҮРЕ		NUMBER		ТҮРЕ	NUMBER		
Coronary	y Care Unit (CCU)		Long Term (Care (LTC)			Re	esidential Treatment-Mental Health			
Crisis Sta	abilization Unit		Medical-Sur	gical			Re	esidential Treatment-Substance Abus	se		
Inpatien	t Mental Health		Medicare Co	ds		Ski	cilled Nursing Facility (SNF)				
Inpatient Substance Abuse Neonatal ICU (NICU)							irgical ICU				
Intensive Care Unit (ICU) Pediatric ICU (PICU)				· ·				Other (List):			
ACCRED	ITATION INFORMAT	TION Plan	so includo so	ny of curr	ont acc	roditatio	n do	ocumentation	·		
								levels of care at this service location.			
ACCREDITING BODY EXP DATE ACCREDITING BO											
ACCR	REDITING BODY	EXP DATE	ACCRE	DITING BODY		EXP DAT	Έ	ACCREDITING BODY	EXP DATE		
TJC	REDITING BODY	EXP DATE	CARF	DITING BODY		EXP DAT	E	ACCREDITING BODY HFAP/AOA	EXP DATE		
	REDITING BODY	EXP DATE		DITING BODY		EXP DAT	E		EXP DATE		
TJC	REDITING BODY	EXP DATE	CARF	DITING BODY		EXP DAT	Ë	HFAP/AOA	EXP DATE		
TJC AAAASF	REDITING BODY	EXP DATE	CARF CCAC	DITING BODY		EXP DAT	E	HFAP/AOA UCAOA	EXP DATE		
TJC AAAASF AAAHC	REDITING BODY	EXP DATE	CARF CCAC CHAP			EXP DAT	E	HFAP/AOA UCAOA OTHER (LIST):	EXP DATE		
TJC AAAASF AAAHC AAUCM ACHC			CARF CCAC CHAP COA DNV/NIAH	0				HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED)	EXP DATE		
TJC AAAASF AAAHC AAUCM ACHC	LOCATION: Provide	er Designat	CARF CCAC CHAP COA DNV/NIAH	O Check all th	nat app	oly for thi	s spe	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED)	EXP DATE		
TJC AAAASF AAAHC AAUCM ACHC	LOCATION: Provide	er Designat	CARF CCAC CHAP COA DNV/NIAH	O Check all th	nat app	oly for thi	s spe	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) ecific location only. I and professional liability.	EXP DATE		
TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a	LOCATION: Provide	er Designat	CARF CCAC CHAP COA DNV/NIAH	O Check all th	nat app	oly for thi both gen	s spe	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) ecific location only. I and professional liability.	EXP DATE		
TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a Type 04 05	LOCATION: Provide Iso submit copy of i Description Health Department Hospice	er Designatinsurance (CARF CCAC CHAP COA DNV/NIAH cion. Please of coverage, for	O Check all th	nat appon, for Type 14 16	bly for thi both gen Descrip Nursing Outpati	s speeral eral tion ; Faci	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) ecific location only. l and professional liability. ility (Intermediate Si			
TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a Type 04 05 06	LOCATION: Provide Iso submit copy of i Description Health Department Hospice Long Term Services 8	er Designatinsurance of the surance	CARF CCAC CHAP COA DNV/NIAH cion. Please of coverage, for	O check all the verification	nat appon, for Type 14 16 17	oly for thi both gen Descrip Nursing Outpati	s speeral tion Faci ent F	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) ecific location only. I and professional liability. ility (Intermediate Si			
TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a Type 04 05 06 07	LOCATION: Provide Iso submit copy of i Description Health Department Hospice Long Term Services & Outpatient Mental H	er Designatinsurance of Supports (CARF CCAC CHAP COA DNV/NIAH ction. Please of coverage, for	O check all the verification [nat appon, for Type 14 16 17 18	Descrip Nursing Outpati Durable Radiolo	s speeral tion ; Faci eent F	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) ecific location only. I and professional liability. ility (Intermediate Strength			
TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a Type 04 05 06 07 08	LOCATION: Provide Iso submit copy of i Description Health Department Hospice Long Term Services & Outpatient Mental H Addiction, Recovery,	er Designatinsurance of Supports (lealth – Trac	CARF CCAC CHAP COA DNV/NIAH cion. Please of coverage, for the coverage of the	O check all the verification [[[check all the verification	nat appon, for Type 14 16 17 18 19	Descrip Nursing Outpati Durable Radiolo Home H	s speeral tion Faci ent F e Med gy	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) ecific location only. I and professional liability. ility (Intermediate Strength			
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TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a Type 04 05 06 07 08 09 10 11	LOCATION: Provide Iso submit copy of i Description Health Department Hospice Long Term Services & Outpatient Mental H Addiction, Recovery, Community MH Reha Hospital - Psychiatric Hospital - General	er Designatinsurance of Supports (lealth – Trace & Treatmer abilitative Section (Pedia)	CARF CCAC CHAP COA DNV/NIAH tion. Please of coverage, for the services (AR ervices (CMHR ervice)	O check all the verification [[[check all the verification	nat appon, for Type 14 16 17 18 19 20 26 27	Descrip Nursing Outpati Durable Radiolo Home H Laborat Federal	s speeral tion gracification g	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) recific location only. I and professional liability. Illity Intermediate Str. S			
TJC AAAASF AAAHC AAUCM ACHC SERVICE Please a Type 04 05 06 07 08 09 10	LOCATION: Provide Iso submit copy of in Description Health Department Hospice Long Term Services & Outpatient Mental H Addiction, Recovery, Community MH Rehalth Hospital - Psychiatric	er Designatinsurance of Supports (lealth – Trace & Treatmer abilitative Section (Pedia)	CARF CCAC CHAP COA DNV/NIAH tion. Please of coverage, for the services (AR ervices (CMHR ervice)	O check all the verification [[[check all the verification	nat appon, for Type 14 16 17 18 19 20 26	Descrip Nursing Outpati Durable Radiolo Home H Laborat Federal Commu	s speeral tion g Faci dent F e Med gy Health cory ly Qu unity ealth	HFAP/AOA UCAOA OTHER (LIST): NONE (NON-ACCREDITED) recific location only. I and professional liability. Illity (Intermediate SI Rehabilitation (PT OT ST) redical Equipment (DME) and Supplies th ualified Health Center (FQHC)			