Molina Healthcare, Inc.
Health Delivery Organization (HDO) Application

INSTRUCTIONS:

Please submit this completed application and required attachments in order to apply for initial credentialing or recredentialing with Molina Healthcare. During initial credentialing, credentialing must be completed prior to completion of a contract for any organization/facility not currently contracted with Molina Healthcare. Approval of your credentialing does not constitute finalization/approval of your contract and network participation.

If your organization has more than one location:

- Complete a separate application for each of your locations if each location has had a separate state, CMS or accreditation survey.
- Complete one application which will cover all your locations if:
  - Your organization has had one state, CMS and/or accreditation survey that covered all your locations on the same date(s), or
  - Your organization is not accredited and not required to be surveyed by any state or federal organization as part of your licensure, registration and/or certification process.

- **This application must be filled out completely with all sections answered:**
  - Do not use white-out on any part of the application.
  - If there is NOT a checkbox in the section header to indicate a why a section is not applicable, the section should be completed by all applicants.

- **The information listed below should accompany the completed application:**
  - ☐ Current organizational or facility licenses/certifications/registrations
  - ☐ A copy of the letter verifying approval of CMS participation (if applicable)
  - ☐ Current liability insurance face sheet
  - ☐ W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility
    (Only Page 1 of this form is needed: http://www.irs.gov/pub/irs-pdf/fw9.pdf)

- If your organization is not accredited by a body listed in Section 4 of this application and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results

- *Incomplete applications will be returned for completion prior to processing.*

- *Please return this application and all attachments to the location specified on your cover letter.*

1. ORGANIZATION INFORMATION: *(Provide physical location information on the following page)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # *(primary)*:	Organization Medicaid # *(primary)*:
Organization TIN *(primary)*:	Organization NPI *(primary)*:
Credentialing Contact Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____	**Billing Address** *(if different than Credentialing)* Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____

2. CURRENT INSURANCE COVERAGE:
(Please attach a copy of your current facility professional/general liability insurance face-sheet)

☐ *Please check here if your facility is not required to carry liability insurance.*

Professional Liability Insurance Information *(if available)*

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:		Coverage amount aggregate:

General Liability Insurance Information *(if no professional liability available)*

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:		Coverage amount aggregate:

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed with Molina Healthcare.
Complete a copy of sections 3-4 of this application for every location where information differs between locations

3. PHYSICAL LOCATION INFORMATION:

(Include any additional information relevant to this location on a separate sheet)

Location DBA
(if different than the Organization DBA)

Other DBAs Previously Used
(if under same ownership)

Is this location Medicare Certified? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location	State provider # *(if applicable, LTC, etc.)*:
Street Address: _____	Is this location handicap accessible? ☐ **Yes** ☐ **No**
Address Line 2: _____	
City: _____ State: _____ Zip: _____	
Phone: _____ Fax: _____	

Please list any languages spoken by office personnel:

Practice Limitations (e.g., age, gender, etc.):

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Please check here if this location is not required to be licensed, certified, or registered by a State agency.*

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

Specialty & Federal Taxonomy Code	Specialty & Federal Taxonomy Code

4. ACCREDITATION / CERTIFICATION *(check all that apply)*:

☐ *Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.*

☐ *Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.*

Accreditation Organization		Date of Last Survey
☐ (CMS)	Medicare Certification *(attach most recent survey and acceptance letter)*	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care	
☐ (ACHC)	Accreditation Commission for Health Care	
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
☐ (ABCOP)	American Board for Certification in Orthotics/Prosthetics	
☐ (ACR)	American College of Radiology	
☐ (ASHI)	American Society for Histocompatibility and Immunogenetics	
☐ (BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)	
☐ (CAP)	College of American Pathologists	
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities	
☐ (COLA)	Committee of Laboratory Accreditation	
☐ (CHAP)	Community Health Accreditation Program	
☐ (CT)	The Compliance Team	
☐ (COA)	Council on Accreditation	
☐ (DNV)	Det Norske Veritas	
☐ (HFAP)	Healthcare Facilities Accreditation Program - AOA	
☐ (HQAA)	Healthcare Quality Association on Accreditation	
☐ (IAC)	The Intersocietal Accreditation Commission	
☐ (NABP)	National Association of Boards of Pharmacy	
☐ (NBAOS)	National Board of Accreditation for Orthotics Suppliers	
☐ (NCQA)	National Commission for Quality Assurance	
☐ (TJC)	The Joint Commission	
☐ (URAC)	URAC, (aka, American Accreditation Healthcare Commission)	
☐ *(*CABC)*	**Commission for the Accreditation of Birth Centers*	

**** Molina only recognizes accreditation by CMS 'Deemed' bodies except for The CABC for 'Birthing Centers' and PPFA for 'Planned Parenthood' facilities.***

ATTESTATION AND RELEASE OF INFORMATION FORM *Modifications Will Not Be Accepted*

RELEASE OF INFORMATION:

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant Molina Healthcare permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize Molina Healthcare to request, receive and inspect any and all records pertinent to consideration of this application.

As a Molina Healthcare facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply Molina Healthcare with any information and documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:

I hereby grant permission for Molina Healthcare to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support Molina Healthcare's quality improvement and utilization review programs.

ATTESTATION:

I certify the information on this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below. I attest that the organization on this application maintains liability insurance as outlined by state requirements.

I acknowledge that decision of participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with Molina Healthcare and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by Molina Healthcare. All services rendered to Molina members must be individually authorized until a written notice of participation and conditions of participation is issued by Molina Healthcare.

This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (https://exclusions.oig.hhs.gov/) and System for Award Management (https://www.sam.gov/SAM/) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Signature: _____
(Stamped signature is not acceptable)

Printed Name: _____ Date: _____