Molina Healthcare of New Mexico, Inc.

APPLICATION CHECKLIST & INSTRUCTIONS

Please complete the below and submit to your Molina Healthcare representative, along with all specified attachments, forms and documents.

Note: Contact your Molina Healthcare representative directly regarding contracting. Please make sure that the information supplied on your organizational credentialing application 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.

The following items are required in order to complete your organizational credentialing.

You must *always* include these documents:

- ☐ Completed Facility Information Form (attached, pg 2)
  (Failure to complete in its entirety for all locations to be credentialed will prevent initiation of credentialing)
- ☐ Completed Organizational Ownership/Controlling Interest Disclosure Form
  (Failure to complete in its entirety for all locations to be credentialed will prevent initiation of credentialing)
- ☐ Complete Organizational Credentialing Application (signed w/in 120 days)
  (Failure to complete in its entirety for all locations to be credentialed will prevent initiation of credentialing)

- ☐ Copy of all organizational licenses, registrations, certificates, etc.
  (For ALL organizational locations that will be contracted with Molina)
- ☐ Copy of CURRENT professional liability (or general, if no professional) insurance face sheet
  (For ALL organizational locations that will be contracted with Molina)
- ☐ Copy of recognized organizational accreditation certificate(s)
  (Recognized accrediting bodies specified in the organizational credentialing application)
- ☐ Copy of W-9 form(s) and the IRS Employer Identification Number letter
  (For ALL organizational locations that will be contracted with Molina)
- ☐ Copy of a State-issued Medicaid enrollment confirmation letter *(showing individual enrollment)*

If your organization is NOT accredited and is CMS certified, you must supply ONE of the following:

- ☐ Copy of the most recent CMS or State on-site survey results

OR

- ☐ Copy of the letter verifying approval of CMS participation and certification.

FACILITY 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.).

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

Legal Name:	Primary TIN:
DBA Name:	Primary NPI:
Primary Specialty (w/ Molina Healthcare):	
Secondary Specialties (w/ Molina Healthcare):	
Will your organization use telemedicine services from New Mexico-based providers?: ◯ YES ◯ NO	Will your organization use telemedicine services from providers who practice from locations/sites outside of NM?: ◯ YES ◯ NO
Do you want your organization listed in Molina's Provider Directory?: ◯ YES ◯ NO	Molina requires electronic claims submission. Will you be capable of submitting claims electronically?: ◯ YES ◯ NO

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

Location Accredited *(if not solo)*: ◯ YES ◯ NO ◯ N/A		Accredited by *(if accredited)*:	
Age/Gender/Other Practice Limitations:			
Physical Street Address:		Suite Floor:	
City:	State:	County:	ZIP:
Phone:	Fax:	E-mail:	

CONTRACTING CONTACT INFORMATION:

Contact Name:	Phone:	E-mail:

CREDENTIALING CONTACT INFORMATION:

Contact Name:	Phone:	E-mail:

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Health Organization Provider Application

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)	
Hospital or Health System Affiliation (If applicable)	
Provider Type:	
Organization Medicare # *(Primary)*:	Organization Medicaid # *(Primary)*:
Organization TIN *(Primary)*:	Organization NPI *(Primary)*:

Ownership Type: (Select one)
☐ Sole proprietorship ☐ City/County/State owned
☐ Corporation/LLC/Partnership ☐ Federally owned

Select One:
☐ For profit ☐ Non-profit

Mailing Address	**Billing Address** *(If different than mailing)*
Street Address:	Street Address:
Address Line 2:	Address Line 2:
City: State: Zip:	City: State: Zip:
Contact:	Contact:
Email:	Email:
Phone: Fax:	Phone: Fax:

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

Professional Liability Insurance Information

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

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (Malpractice, general, etc.):
Coverage Amount per Occurrence:		Coverage Amount Aggregate:

New Mexico
Health Organization Provider Application

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

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 a satellite facility? ☐ **Yes** ☐ **No** **If yes, does the facility follow the same policies and procedures as the main facility?** ☐ **Yes** ☐ **No** **Please list the name of the main facility:**	
Is this location Medicare-certified? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Number of Medicare-certified beds?	Are interpreters available? ☐ **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**:**	Location is handicap accessible? ☐ **Yes** ☐ **No**
Address Line 2**:**	American with Disabilities (ADA) Complaint: ☐ **Yes** ☐ **No**
City: State: Zip:	Describe your service area *(States, counties, cities, etc.)*:
Phone: Secure Fax:	
Practice limitations (e.g., age, gender, etc.)	TDD capability: ☐ **Yes** ☐ **No**
Location offers pediatric services? ☐ **Yes** ☐ **No**	Please list any languages spoken by office personnel:

Hours of Operation

Standard Business Hours		Evening Hours (Any hours after 5 p.m.)		Weekend Hours	
Monday		Monday		Saturday	
Tuesday		Tuesday		Sunday	
Wednesday		Wednesday			
Thursday		Thursday			
Friday		Friday			

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:				

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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 (CYFD) Children,Youth and Families Department (New Mexico) conducts routine surveys of your organization for license, registration, or clinical oversight.*

☐ *Please check here if your organization is NOT accredited.*

List Accreditation Organizations and Attach Copies of Current Certificates	Date of Last Survey

5. CREDENTIALING PROGRAM:
(All questions MUST be answered by ALL organizations.)

Organizational Service Provider Screening
(Mark ONE option for each question.)

1) Please select the method utilized to verify the license/certification of individuals rendering services for your organization:

- ☐ Online directly with the appropriate State and/or Federal licensure or certification board
- ☐ Background check agency, contracted organization, or vendor
- ☐ Other process (please describe):
- ☐ No process (please explain):

2) Please indicate the method utilized to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:

- ☐ Online directly with the appropriate State and/or Federal licensure or certification board
- ☐ Obtaining a current copy of the license/certification
- ☐ Background check agency, contracted organization, or vendor
- ☐ Other process (please describe):
- ☐ No process (please explain):

3) Please indicate the method utilized to verify the <u>identity</u> of individuals rendering services for your organization:

- ☐ Verification of a state driver's license or other government identification
- ☐ Background check agency, contracted organization, or vendor
- ☐ Other process (please describe):
- ☐ No process (please explain):

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4) Please indicate the method utilized to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals 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) are rendering services:

- ☐ Federal and/or State criminal background check(s)
- ☐ Background check agency, contracted organization, or vendor
- ☐ Search a State 'Misconduct Registry' or equivalent
- ☐ Other process (please describe):
- ☐ No process (please explain):

5) Has your organization or any of its authorized representatives ever been convicted of, pled guilty to, or pled nolo contendre to any legal actions (excluding medical malpractice and misdemeanors)?

☐ NO ☐ YES *(provide an explanation)*:

6) Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?

☐ NO ☐ YES *(provide an explanation)*:

7) Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military, or State Department of Health programs?

☐ NO ☐ YES *(provide an explanation)*:

8) At any time, has any license or certification held by the organization or its branch locations ever been revoked, denied, or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which may lead to one of these outcomes?

☐ NO ☐ YES *(provide an explanation)*:

9) Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?

☐ NO ☐ YES *(provide an explanation)*:

10) At any time, has any third party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management or quality of care issues?

☐ NO ☐ YES *(provide an explanation)*:

11) Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?

☐ NO ☐ YES *(provide an explanation)*:

12) Has the facility been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?

☐ NO ☐ YES (provide an explanation):

13) Does each service location associated with the facility follow the policies and procedures as defined by the facilities service location?

☐ NO ☐ YES (provide an explanation):

14) Is the location within one block of a public transportation stop?

☐ NO ☐ YES (provide an explanation):

15) Please submit your organization's Quality Improvement Plan.

Additional specialty and roster information may be requested by credentialing entity.
Please attach a list of physical locations.

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Health Organization Provider Application

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 the Managed Care Organization permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Managed Care Organization to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply the Managed Care Organization with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:

I hereby grant permission for the Managed Care Organization to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support the Managed Care Organizations 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 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, the Managed Care Organization 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 the Managed Care Organization. All services rendered to its Members must be individually authorized until a written notice of participation and conditions of participation is issued by the Managed Care Organization.

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 (http://oig.hhs.gov/exclusions/exclusions_list.asp) and System for Award Management (https://www.sam.gov/portal/public/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: _____

INSTRUCTIONS:

Complete all items as noted below and submit application, addendum and additional attachments to your contracting representative, in order, to apply for credentialing with Molina Healthcare of New Mexico, Inc. Please note that completed and approved credentialing is required prior to completion of a contract for any organization/facility not currently contracted with Molina Healthcare, and that approval of your credentialing does not constitute finalization/approval of your contract and network participation.

- **A separate application is required for:**
  - each location (or group of locations) that shares CMS certification under one primary specialty
  - each location (or group of locations) that shares accreditation (on pg. 5) under one primary specialty
  - each location (or group of locations) that has a different primary specialty

- **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.
  - Section 6 MUST be completed by all applicants.

- **The information listed below should accompany the completed application:**
  - ☐ Current organizational or facility licenses/certifications/registrations
    - ☐ *(If above is unavailable: attach a list of individual service provider names, specialties & license numbers)*
  - ☐ Current professional and general liability insurance face sheet (or general liability if professional is unavailable)
  - ☐ 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)
  - ☐ Completed ownership/controlling interest disclosure form
    (This form can be supplied by your contracting or credentialing representative)

- **If your organization is not accredited by a body listed in Section 5 of this application and your organization is required to be certified by CMS or the State, we also request one of the following documents:**
  - ☐ A copy of the most recent CMS or State on-site survey results
  - ☐ A copy of the letter verifying approval of CMS participation

- ***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.***

Molina Healthcare of New Mexico, Inc.
Health Delivery Organization (HDO) Addendum

Please complete the following information as it pertains to your health delivery organization.

1. LICENSED HEALTHCARE PRACTITIONER INFORMATION:

(Only needed for licensed practitioners, and only if location is not surveyed/accredited and holds no licenses/certificates/registrations)

Name	NPI	Date of Birth	Specialty	License #

2. PRIMARY CONTRACTED SPECIALTY & TAXONOMY:

(If each location will be contracted for a different specialty, complete a separate full application for each location)
(If there are multiple primary specialties being contracted with Molina, check ALL that apply)

	Specialty & Federal Taxonomy Code		Specialty & Federal Taxonomy Code
	Agencies		
☐	Case Management [251B00000X]	☐	Hospice - Community Based [251G00000X]
☐	Day Training - Developmentally Disabled Services [251C00000X]	☐	In Home Supportive Care [253Z00000X]
☐	Early Intervention Provider [252Y00000X]	☐	Nursing Care [251J00000X]
☐	Foster Care [253J00000X]	☐	All-Inclusive Care for the Elderly (PACE) [251T00000X]
☐	Home Health [251E00000X]	☐	Public Health [251K00000X]
☐	Home Infusion [251F00000X]	☐	Supports Brokerage [251X00000X]
	Ambulatory Care Clinics/Centers		
☐	Adolescent & Children Mental Health [261QM0855X]	☐	Occupational Therapy [261QX0100X]
☐	Day Care - Adult [261QA0600X]	☐	Oncology - Radiation [261QX0203X]
☐	Adult Mental Health [261QM0850X]	☐	Ophthalmologic Surgery [261QS0132X]
☐	Ambulatory Family Planning [261QA0005X]	☐	Oral and Maxillofacial Surgery [261QS0112X]
☐	Ambulatory Surgical Center [261QA1903X]	☐	Physical Therapy [261QP2000X]
☐	Amputee Center [261QA0900X]	☐	Public Health - Federal [261QP0904X]
☐	Augmentative Communication [261QA3000X]	☐	Public Health - State or Local [261QP0905X]
☐	Birthing Center [261QB0400X]	☐	Radiology [261QR0200X]
☐	Critical Access Hospital [261QC0050X]	☐	Radiology - Mammography [261QR0206X]
☐	Emergency Care [261QE0002X]	☐	Radiology - Mobile [261QR0208X]
☐	Endoscopy [261QE0800X]	☐	Rehabilitation (PT/OT/ST) [261QR0400X]
☐	End-Stage Renal Disease (ESRD)/Dialysis [261QE0700X]	☐	Rehabilitation - Cardiac [261QR0404X]
☐	Federally Qualified Health Center (FQHC) [261QF0400X]	☐	Rehabilitation - Outpatient (CORF) [261QR0401X]
☐	Infusion Therapy Clinic [261QI0500X]	☐	Rehabilitation - Substance Use Disorders [261QR0405X]
☐	Lithotripsy [261QL0400X]	☐	Rural Health Clinic (RHC) [261QR1300X]
☐	Magnetic Resonance Imaging (MRI) [261QM1200X]	☐	Speech Therapy [261QH0700X]
☐	Day Care - Medically Fragile Infnts/Chldrn [261QM3000X]	☐	Urgent Care [261QU0200X]
☐	Mental Health - Outpatient [261QM0801X]		

2. PRIMARY CONTRACTED SPECIALTY & TAXONOMY – Continued:

(If each location will be contracted for a different specialty, complete a separate full application for each location)
(If there are multiple primary specialties being contracted with Molina, check ALL that apply)

	Specialty & Federal Taxonomy Code		Specialty & Federal Taxonomy Code
	Hospitals		
☐	Chronic Disease [281P00000X]	☐	Long Term Care [282E00000X]
☐	Chronic Disease - Children [281PC2000X]	☐	Psychiatric [283Q00000X]
☐	General Acute Care [282N00000X]	☐	Rehabilitation [283X00000X]
☐	General Acute Care - Children [282NC2000X]	☐	Rehabilitation - Children [283XC2000X]
☐	General Acute Care - Critical Access [282NC0060X]	☐	Religious Nonmedical Health Care [282J00000X]
☐	General Acute Care - Rural [282NR1301X]	☐	Specialty [284300000X]
☐	General Acute Care - Women [282NW0100X]		
	Laboratories		
☐	Clinical Medical [291U00000X]	☐	Physiological (Independent Diagnostic/IDTF) [293D00000X]
☐	Dental [292200000X]		
	Nursing/Custodial Care Organizations		
☐	Assisted Living [310400000X]	☐	Intermediate Care - Mental Illness [310500000X]
☐	Assisted Living - Bhvrl Disturbances [3104A0630X]	☐	Intermediate Care - Mental Retarded [315P00000X]
☐	Assisted Living - Mental Illness [3104A0625X]	☐	Intermediate Care - Nursing [313M00000X]
☐	Custodial Care [311Z00000X]	☐	Skilled Nursing [314000000X]
☐	Hospice - Inpatient [315D00000X]	☐	Skilled Nursing - Pediatric [3140N1450X]
	Residential Care Organizations		
	Suppliers		
☐	Blood Bank [331L00000X]	☐	Eye bank [332G00000X]
☐	Durable Medical Equip [332B00000X]	☐	Eyewear [332H00000X]
☐	Durable Medical Equip - Customized [332BC3200X]	☐	Hearing Aid Equipment [332S00000X]
☐	Durable Medical Equip - Dialysis [332BD1200X]	☐	Home Delivered Meals [332U00000X]
☐	Durable Medical Equip - Nursing [332BN1400X]	☐	Medical Food [335G00000X]
☐	Durable Medical Equip - Oxygen/Respiratory [332BX2000X]	☐	Organ Procurement [335U00000X]
☐	Durable Medical Equip - Parental/Enteral Ntrtn [332BP3500X]	☐	Pharmacy [333600000X]
☐	Emergency Response Services [333300000X]	☐	Portable X-ray [335V00000X]
	Transportation Vendors		
☐	Ambulance [341600000X]	☐	Bus [347B00000X]
☐	Ambulance - Air [3416A0800X]	☐	Non-Emergency Medical (VAN) [343900000X]
☐	Ambulance - Land [3416L0300X]	☐	Secured Medical (VAN) [343800000X]
☐	Ambulance - Water [3416S0300X]	☐	Broker [347E00000X]
	Atypical Service Organizations (No Federal Taxonomy)		
☐	Adaptive Assistance Devices [NONE]	☐	Home/Environment Modification [NONE]
☐	Community Health Workers [NONE]	☐	Homemaker Services [NONE]
☐	Community Transition Services - Housing [NONE]	☐	Independent Living Assistance/Adult Companion [NONE]
☐	Core Services Agencies [NONE]	☐	Nutritional Consultation Services [NONE]
☐	Employment Support [NONE]	☐	Personal Care Services [NONE]
☐	Financial Assessment/Risk Reduction Services [NONE]	☐	Pest Control [NONE]
	Other Specialties *(List the Specialty and Federal or State Taxonomy)*		
☐		☐	
☐		☐	

3. 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*	
☐ *(*PPFA)*	**Planned Parenthood Federation of America*	

**** Molina only recognizes accreditation by CMS 'Deemed' bodies with the exception of the CABC for 'Birthing Centers' and PPFA for 'Planned Parenthood' facilities.***