NY - Provider Contract Request Form

If you are not currently a contracted provider with Molina Healthcare of New York, Inc. and you are interested in joining our network of quality health care providers, please email this **completed form** to mhnyprovidercontracting@molinahealthcare.com.

If you are adding, terminating, or changing providers for a participating group, please do not complete and submit this form. Please submit your request to mhnynetworkoperations@molinahealthcare.com

Contact Information	
Requestor Name:	Requestor Phone:
Requestor Email:	Requestor Fax:

Provider Identification	
Group Name (Legal & DBA):	
Individual / Group Tax ID*:	Group Specialty*:
Individual / Group Billing NPI:	New York Medicaid ID:

**please list additional TINs and specialties in "Additional Information" section*

Please Select Provider Type					
☐ PCP	☐ Group	☐ Multi-Specialty	☐ FQHC	☐ IPA	☐ Behavior Health
☐ Other Specify:					

Provider Information
Number of Practitioners part of the group:
Cities/Communities served (i.e. what is your service area):
Primary Service location address:
Hospital Affiliation(s):
CAQH Provider Number:

Provider Acknowledgement

☐ **I have read and understand the statement below (request will not be considered until this box is checked).**

Completion of the above information is not confirmation of your participation status with Molina Healthcare of New York. Determination to offer a contract is subject to Network review. If approved, final contractual status is based upon your ability to meet credentialing requirements and contractual obligations. We will notify you when your request is complete and eligible for department review.