8300 NW 33rd St, Ste.400
Doral, FL 33122
(888) 562-5442

Request for Contract

Complete and return via EMAIL to: MFLProviderContracting@MolinaHealthCare.com
or FAX to: (877) 731-7213

Practitioner / Facility Name	
Primary Specialty	
Other specialties (secondary) if applicable	
Practitioner's Title (MD, DO, PA, etc.)	
Specialist or Primary Care Provider?	
Individual NPI #	
Medicaid ID #	
Group NPI # *(if multiple, please state so)*	
TAX ID #	
Legal Name	
DBA (if applicable)	
☐ **DBA name is the billing name (box 33)**	☐ **DBA name is the name of the service location only (box 32)**

Primary Service Location:

Location Name				
Address				
City	State		ZIP	
Phone#		Fax#		
Hours of Operation				

Billing Address:

Address				
City	State		ZIP	
Phone#		Fax#		
Billing Contact				

PCMH or PCSP Recognition: _____ Y _____ N

Office Contact: **Email:** **Phone:**

***Please attach a roster showing additional Practitioners/Service Locations (if applicable) as well as a W-9 Form**

Are you currently participating in the MMA Physician Incentive Program (MPIP) with another Health Plan? _____ Yes _____ No

***If so, please provide a copy the notification letter regarding your group's qualification for the MPIP**