



## ENROLLMENT APPLICATION REQUIRED DOCUMENTATION CHECKLIST

Please submit current copies of **ALL** the documentation listed below. Any missing or inaccurate information will delay the enrollment process.

- W-9 form.
- Disclosure and Ownership Form (Facility Credentialing ONLY)
- NYS License
- NYS MMID
- DEA
- Proof of Malpractice Insurance
- Group Roster
- Supervising/Collaboration physician form (midlevel's only)
- Office Contacts Sheet Completed
- Attestation form completed (see form for details)

**Please send these forms to:** [pfmemails@monroeplan.com](mailto:pfmemails@monroeplan.com)

Once the practitioner enrollment form has been received the provider will be enrolled with Monroe Plan for Medical Care IPA, and ***your request for credentialing will be sent to Molina Health Plan***. Once credentialing has been approved by Molina, an approval communication will be sent out with the participating effective date from MOLINA. Until this approval letter from Molina is received the provider is considered a non-participating provider until credentialing is complete. Credentialing can take up to 60 days to complete.

To ensure the process is quick and efficient, please make sure the provider's CAQH application is updated and attested to, and that Molina Health Plan is authorized to view the application.

**\*\*Credentialing will not be initiated if you do not have an active CAQH profile or authorize Molina Health Plan to view your application. Your application will be considered incomplete, and you will NOT be a participating provider in the network.**

1120 Pittsford-Victor Road

Pittsford, NY 14534

[pfmemails@monroeplan.com](mailto:pfmemails@monroeplan.com)



## APPLICATION FOR PROVIDER ENROLLMENT

To begin the enrollment process, please complete the information appropriate to your specialty. Complete and return with the items on the attached checklist. All information must match NPPES.

Please ensure that your CAQH information is completed, and Molina is authorized to view with the most up-to-date information.

Today's Date:	Requested Effective Date:	Group Name:
Group TAX ID:	Group NPI:	Provider Name:
Individual NPI#:	SSN#:	DOB:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Provider License#/State:	DEA Certificate#:
CAQH#: MEDICAID #: MEDICARE #:	PCP <input type="checkbox"/> YES <input type="checkbox"/> NO  Specialist <input type="checkbox"/> YES <input type="checkbox"/> NO  Hospitalist <input type="checkbox"/> YES <input type="checkbox"/> NO	Language(s) other than English:
Primary Specialty:	Second Specialty:	Taxonomy Code:
Applying as: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allies/Consulting Health Professional	Are you board-certified? <input type="checkbox"/> YES <input type="checkbox"/> NO  If yes, board name and date:	Experienced HIV/AIDS Provider: <input type="checkbox"/> YES <input type="checkbox"/> NO

Have you, your agent or managing employee ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?

Yes    No

**If yes, please provide the following:**

Name/Title: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_



<b>Please select only one provider type:</b>	<input type="checkbox"/> Anesthesiologist <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalist <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Pathologist	<input type="checkbox"/> Audiologist (AUD) <input type="checkbox"/> Certified Diabetic Educator (CDE) <input type="checkbox"/> Doctor of Podiatric Medicine (DPM) <input type="checkbox"/> Enterostomal Therapy <input type="checkbox"/> Medical Doctor (MD) <input type="checkbox"/> Certified Nurse Midwife (CNM) <input type="checkbox"/> Chiropractor (DC) * <input type="checkbox"/> Occupational Therapist (OT)	<input type="checkbox"/> Optometrist <input type="checkbox"/> Oral Maxillofacial Surgery (DMD/DDS) <input type="checkbox"/> Osteopathic Doctor (DO) <input type="checkbox"/> Registered Dietician (RDE) <input type="checkbox"/> Physical Therapist (PT) <input type="checkbox"/> Speech Pathologist (SP/SLP) <input type="checkbox"/> Pain Management  <i>* Provider Type is applicable to Essential Plan Only</i>
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**If you selected Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens or Pathologist, you must complete the disclosure questions on the last page**

**Please note: A correspondence street level address must be applied when a remittance address is a PO Box. Use additional sheets when needed for multiple addresses.**

<b>Address A</b>	Street: _____ STE: _____ City: _____ State: _____ ZIP Code: _____  Accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO    PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO Panel? <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSE Directory? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="radio"/> <b>Primary Office</b> <input type="radio"/> <b>Additional Office</b> <input type="radio"/> <b>Correspondence</b> <input type="radio"/> <b>Remittance</b> <input type="radio"/> <b>Medical Record</b>
Phone: _____ Fax: _____	<b>Office Hours:</b>	Handicap accessible: Y or N <input type="checkbox"/> <input type="checkbox"/> Public Transportation: Y or N <input type="checkbox"/> <input type="checkbox"/>

<p><b>Address B</b></p>	<p>Street: _____</p> <p>STE: _____</p> <p>City: _____</p> <p>State: _____ ZIP Code: _____</p> <p>Accepting new patients?    <input type="checkbox"/> YES <input type="checkbox"/> NO    PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO          Panel?    <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSE          Directory?    <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<ul style="list-style-type: none"> <li><input type="radio"/> Primary Office</li> <li><input type="radio"/> Additional Office</li> <li><input type="radio"/> Correspondence</li> <li><input type="radio"/> Remittance</li> <li><input type="radio"/> Medical Record</li> </ul>
<p>Phone: _____</p> <p>Fax: _____</p>	<p><b>Office Hours:</b></p>	<p>Handicap accessible: Y or N <input type="checkbox"/>   <input type="checkbox"/></p> <p>Public Transportation: Y or N <input type="checkbox"/>   <input type="checkbox"/></p>
<p><b>Address C</b></p>	<p>Street: _____</p> <p>STE: _____</p> <p>City: _____</p> <p>State: _____ ZIP Code: _____</p> <p>Accepting new patients?    <input type="checkbox"/> YES <input type="checkbox"/> NO    PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO          Panel?    <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSE          Directory?    <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<ul style="list-style-type: none"> <li><input type="radio"/> Primary Office</li> <li><input type="radio"/> Additional Office</li> <li><input type="radio"/> Correspondence</li> <li><input type="radio"/> Remittance</li> <li><input type="radio"/> Medical Record</li> </ul>
<p>Phone: _____</p> <p>Fax: _____</p>	<p><b>Office Hours:</b></p>	<p>Handicap accessible: Y or N <input type="checkbox"/>   <input type="checkbox"/></p> <p>Public Transportation: Y or N <input type="checkbox"/>   <input type="checkbox"/></p>
<p><b>Address D</b></p>	<p>Street: _____</p> <p>STE: _____</p> <p>City: _____</p> <p>State: _____ ZIP Code: _____</p> <p>Accepting new patients?    <input type="checkbox"/> YES <input type="checkbox"/> NO    PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO          Panel?    <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSE          Directory?    <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<ul style="list-style-type: none"> <li><input type="radio"/> Primary Office</li> <li><input type="radio"/> Additional Office</li> <li><input type="radio"/> Correspondence</li> <li><input type="radio"/> Remittance</li> <li><input type="radio"/> Medical Record</li> </ul>

**OFFICE CONTACT INFORMATION**

Please use this space for indicating the best points of contact for each category. All email communications will also be sent to the email listed below.

Best contact (Please list name or N/A)	Email	Phone Number
Credentialing-		
Office Manager-		
Quality-		
Clinical-		
Pharmacy-		
Billing-		

**Authorized person completing form:**

<b>Name:</b>	<b>Phone:</b>	<b>Email:</b>
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### Supervising/Collaboration Physician Form

<b>Name of Midlevel:</b>	
<b>NP/PA:</b>	
<b>NPI:</b>	
<b>Name of Supervising/Collab Physician:</b>	
<b>NPI of Physician:</b>	
<b>Effective date:</b>	

**Authorized person completing form:**

<b>Name:</b>	<b>Phone:</b>	<b>Email:</b>
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**Hospital Affiliations:**

Hospital Name	Hospital Address

**Office Hours**

Primary Location:			Additional Location:		
Day:	Office Open:	Office Close:	Day:	Office Open:	Office Close:
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

**Office Contact Information:**

Contact Name:	Phone Number:
Contact Email Address:	
Contact Type: <input type="checkbox"/> Billing Manager <input type="checkbox"/> Office Manager <input type="checkbox"/> Provider <input type="checkbox"/> Office Staff <input type="checkbox"/> Other:	

**Application for Practitioner Enrollment**  
Disclosure Questions for Non-Credentialed Practitioners

**Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens and Pathologist**  
**Must** complete the following disclosure questions:

1. Has your license, registration, or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?  
 Yes  No  NA
  
2. Have your clinical privileges or medical staff membership at any hospital or health care institution (either voluntarily or involuntarily) ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board?  
 Yes  No  NA
  
3. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)?  
 Yes  No  NA
  
4. Has your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certificates(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?  
 Yes  No  NA
  
5. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct?  
 Yes  No  NA
  
6. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?  
 Yes  No  NA
  
7. Has your Professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?  
 Yes  No  NA

**“I hereby attest, to the best of my knowledge that the information on this form is true accurate, and complete.”**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_