Non-Par Provider Contract Request Form

If you are not currently a contracted provider with Molina Healthcare of Illinois and are interested in joining our network of quality health care providers, please email the completed form to Molina.Illinois@MolinaHealthcare.com or fax to the attention of Provider Contracts at 630-571-1220.

Provider Name: ____

Provider Type/Specialty: ____

Medicaid ID Number: ____

Practice Name: ____

*****(If your practice is a group practice, please provide the names and specialties of all practitioners in the group. You may attach a separate sheet if necessary.)

Mailing Address: ____

Primary Office Location (if different from mailing address): _________________________________

County: _______________________________ Person Completing This Form: ____________________

Phone: __________________________ Provider TIN: ______________________________________

Email Address: ____

Are all practitioners employed physicians of the group? ☐ Yes or ☐ No

If NO: Please be advised that separate Provider Services Agreements will need to be completed and signed by each practitioner in the group. Further information will be provided via mail.

Any additional information you would like to include relative to your practice:

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If your request is approved, you will be contacted by a contract manager within 10 days.

If you have any questions regarding completion of this form, contact Provider Services at (855) 866-5462.

*** Please note that the completion of the above information is not confirmation of your participation status with Molina Healthcare of Illinois. Final contractual status is based upon your ability to meet credentialing standards and any additional contractual obligations.