Virginia Guide to Provider Forms

Note: Providers must be screened, enrolled (including signing a Department provider participation agreement), and periodically re-validated in the Department's Medicaid Enterprise System (MES) Provider Services Solution (PRSS), before contracting with Molina and participating in the network.

SECTION 1: Initial Information (All)	
Component	**Description**
Initial Instructions	Please review all details within Section 1 (Initial Information), and then proceed to the appropriate section of this guide to complete necessary documentation: • Section 2: Outlines actions for New Facilities (Health Delivery Organizations) or their new locations/services. • Section 3: Outlines actions for New Groups/Practitioners • Section 4: Outlines actions for all entities, regarding various types of data changes.
Enclosed Forms	1. Provider Information Form (PIF): This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare. 2. Attachment D: This form is used to determine the types of services the provider offers, per location. 3. W-9: This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name, and Tax ID when received with a PIF. 4. ADA Attestation Form: Providers use this form to attest to their compliance with American Disabilities Act (ADA) requirements for each physical service location.
Contact Information	If you have additional questions, please contact Molina Healthcare's Provider Services department at (800) 424-4524, between the hours of 8 a.m. to 6 p.m. ET, Monday through Friday. You many also email: MCCVA-Provider@MolinaHealthcare.com.
SECTION 2: New Facility (Health Delivery Organization)	
ACTION	**Please read through all instructions. Each applicable section must be completed. ALL DOCUMENTS MUST BE COMPLETE, WHEN RETURNED FOR PROCESSING.**
New Facility or New Facility location(s) Including hospitals, ambulatory surgical centers, home health agencies, Durable Medical Equipment (DME) suppliers, SNFs, urgent care centers, behavioral health and substance abuse facilities	1. Complete Attachment D: Services Provided, for each service location 2. Separately—Email or fax the completed Organization (HDO) Application(s) *This application can be found on Molinahealthcare.com under the Provider Contracting and Credentialing Forms section.*
New Service for an existing location	1. Complete Section A of Provider Information Form 2. Complete Attachment D: Services Provided *If new service requires additional licensure, submit license with Attachment D.*

Virginia Guide to Provider Forms

SECTION 3: New Group/Practitioners	
ACTION	**Please read through all instructions. Each applicable section must be completed. ALL DOCUMENTS MUST BE COMPLETE, WHEN RETURNED FOR PROCESSING.**
Add a provider to a group practice	• PIF—Complete Section A and Section L* * Section L can be copied when adding multiple providers to the same service location • Complete Attachment D (*for ALL providers)* • Complete CAQH (*for ALL providers)* Complete CAQH Provider Data Form, and ensure your CAQH application is complete and up to date (Attested). You will also need to update and give Molina Healthcare permission to review. Visit the website at http://www.caqh.org. *If you do not have a CAQH number: Visit the CAQH website and complete the CAQH application enrollment process. Ensure that your CAQH number has been reported to Molina Healthcare on provider enrollment forms and rosters. You will also need to give Molina Healthcare permission to review.*
Add a practitioner to an additional service location, within same group	• PIF—Complete Section A and • Complete Section G for each additional location within the same group * Ensure Section L has been completed for first location, with provider's information. Then, complete Section G above for each additional new/changed address with same practice. You may copy Section G, multiple times as needed if provider practices at multiple locations. *(A roster with all information requested in Sections A, L and G may also be submitted in lieu of completing form for additional locations).*
Add/update services for a Practitioner/Group Member at existing location(s)	• PIF—Complete Section A • Complete Attachment D (*for ALL providers)*
Group: Add a new group practice under the same Tax Identification Number (TIN)	• PIF—Complete Section A and Section G • Submit a W-9 • Complete Attachment D *(for ALL providers)* • Submit a sample claim form (de-identified)
SECTION 4: Data Changes	
ACTION	**You will need to complete the sections identified below on the Provider Information Update Form (PIF) and any supplemental documents, as outlined per section. ALL DOCUMENTS MUST BE COMPLETE, WHEN RETURNED FOR PROCESSING**
Change TIN only	• PIF—Complete Section A and Section B • Submit a W-9 • Submit a sample claim form (de-identified) If changing your Group/Practice Name and Tax ID Number, a new contract may be required. • Please contact Molina Healthcare Provider Services at MCCVA-Provider@MolinaHealthcare.com.
Group/Provider NPI Change	• PIF—Complete Section A and Section C

Virginia Guide to Provider Forms

SECTION 4: Data Changes (continued)	
ACTION	**You will need to complete the sections identified below on the Provider Information Update Form (PIF) and any supplemental documents, as outlined per section. ALL DOCUMENTS MUST BE COMPLETE, WHEN RETURNED FOR PROCESSING**
Change group name only	• PIF—Complete Section A and Section D • Submit a W-9 • Submit a sample claim form (de-identified)
Individual name change	• PIF—Complete Section A and Section E • Complete Attachment D *(for ALL providers)*
Change a phone/fax/email	• PIF—Complete Section A and Section F
Change or add a service location	• PIF—Complete Section A and Section G • Complete Attachment D (*for ALL providers)* • Complete ADA Attestation Form (*for ALL providers)*
Closing a service location	• PIF—Complete Section A and Section H
Change the pay-to/billing address	• PIF—Complete Section A and Section I • Submit a W-9 • Submit a sample claim form (de-identified)
Terming a provider	• PIF—Complete Section A and Section J Term letter on your organization's letterhead
Provider directory update	• PIF—Complete Section A and Section K
Panel update	• PIF—Complete Section A and Section K
Hospital affiliations update	• PIF—Complete Section A and Section K

Provider Information Update Form (PIF)

Submission date: _____/_____/_____

SECTION A

This form and the associated documentation are required to notify Molina Healthcare of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at Molinahealthcare.com

Name of person completing this form: _____

Contact phone and email (for questions regarding form): _____

Type of group/provider (select all that apply):

☐ PCP ☐ Specialist ☐ ARTS ☐ Behavioral Health ☐ Medical Group
☐ Ancillary ☐ LTSS ☐ FQHC/RHC ☐ Urgent Care ☐ Hospital ☐ Other

Current group/practice information *(All fields in this section are required)*

Group/practice name: _____

Group/practice tax ID:_____ Group/practice Medicaid ID: _____

Group/practice NPI:_____ Contact phone number: _____

Email address:_____ Contact name: _____

If changing your group/practice name and Tax ID Number, a new contract may be required. Please contact Molina Healthcare Provider Services at MCCVA-Provider@MolinaHealthcare.com.

SECTION B

Tax ID Number change Effective date:_____/____/_____

Previous Tax ID Number:_____ New Tax ID Number: _____

SECTION C

Group/Individual NPI change or addition Effective date:_____/____/_____

☐ Group ☐ Individual *(If adding an NPI, do not fill out "Previous NPI" line.)*

Group/individual name: _____

Previous NPI:_____ New NPI: _____

SECTION D

Group/practice name change Effective date: _/_/_____

Previous group/practice name:_____ Medicaid ID: _____

New group/practice name:_____ Medicaid ID: _____

Provider Information Update Form (PIF)

SECTION E

Individual practitioner name change Effective date: _/_/_____

Previous name: _____ New name: _____

Practitioner NPI: _____

SECTION F

Change phone/fax/email Effective date: _/_/_____

Previous phone number: _____ New phone number: _____

Previous fax number: _____ New fax number: _____

Previous email: _____ New email: _____

Affected address: _____ City/State/Zip: _____

SECTION G

Change or add a service location

☐ Add service location ☐ Change service location Effective date: ____/____/_____

☐ Add a provider to a service location ☐ Change service location for a provider **Provider NPI**: _____

Also complete the ADA Attestation Form for all new service locations.

Previous address	New address
Service location name: _____	Service location name: _____
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City/State/Zip: _____	City/State/Zip: _____
Phone number: _____	Phone number: _____
Fax number: _____	Fax number: _____
Email: _____	Email: _____
	Is telehealth offered at new location? ☐ Yes ☐ No

Practice website: _____

Office hours (new location): _____

* If adding/changing provider service location, ensure Section L is completed for first location, with provider's information. Then, complete Section G above for each additional new/changed address with same practice. You may copy Section G, multiple times as needed if provider practices at multiple locations. *(A roster with all information requested in Sections A, L and G may also be submitted in lieu of completing form for additional locations).*

Provider Information Update Form (PIF)

SECTION H

Closing a service location Effective date:_____/____/_____

Address 1: _____

Address 2: _____

City/State/Zip: _____

Reason: _____

Authorized signatory (printed):_____

Authorized signatory (sign): _____

Phone number:_____ Fax number: _____

Email:_____ Date signed:_____/____/_____

SECTION I

Billing address change Effective date:_____/____/_____

Previous billing information	New billing information
Billing Contact:_____	Billing Contact: _____
Address 1:_____	Address 1: _____
Address 2:_____	Address 2: _____
City/State/Zip:_____	City/State/Zip: _____
Phone number:_____	Phone number: _____
Fax number:_____	Fax number: _____
Email:_____	Email: _____

Is this a notice address change? ☐ Yes ☐ No

The notice address is the particular party's address for delivery or mailing of notice purposes.

Provider Information Update Form (PIF)

SECTION J

Terminating a provider

A termination letter is required on company letterhead and must include the following: group name, group tax ID, group NPI, name of the provider to be termed, provider NPI, effective date of termination, reason for termination, andaddress of practice location(s). *(Please attach letter to this form, upon submission)*

If terming provider is a PCP, who will assume patient panel?

Provider name (Last, First, MI):_____Provider NPI: _____

SECTION K

Provider directory update

Provider name:_____Provider NPI: _____

Address:_____City/State/Zip: _____

☐ PCP ☐ Specialist

K.1: Panel update Effective date:____/____/_____

☐ Existing patients only ☐ Close panel to all members ☐Open panel

Reason *(required)*: _____

K.2: Provider directory update Effective date:____/____/_____

☐ Include in provider directory ☐ Exclude from provider directory

Reason *(required)*: _____

K.3: Hospital affiliations update Effective date:____/____/_____

☐ Add hospital affiliation(s) ☐ Remove hospital affiliation(s)

Name of hospital(s): _____

Provider Information Update Form (PIF)

SECTION L

Provider joining a group/practice Effective date:_____/_____/_____Locum tenen? ☐ Yes ☐ No

Provider name (Last, First, MI): _____

Provider type (MD, DO, DC, PHD, DPM, etc.):_____Date of birth: _____

Last four digits of Social Security #:_____Individual NPI:_____CAQH Provider Number: _____

Provider ethnicity: ☐ African American ☐ Asian/Pacific Islander ☐ Alaskan/American Indian

☐ Caucasian ☐ Hispanic ☐ Other

Group/practice name: _____

Group/practice address: _____

City/State/Zip: _____

Phone number:_____Fax number: _____

Email address: _____

Office hours:_____**Include in directory?** ☐ Yes ☐ No

VA Medicaid provider ID:_____Medicare provider ID: _____

Provider must be registered with DMAS to provide Medicaid services. Please visit vamedicaid.dmas.virginia.gov for registration information.

Provider specialty:_____Secondary specialty: _____

Provider specialty must align with registered taxonomy for NPI.

Applying as: ☐ PCP ☐ Specialist ☐ Hospitalist ☐ Other If PCP, list requested panel size (max. 1,500)_____

Note: Please ensure the provider has completed and/or re-attested to the CAQH application and has authorized Molina Healthcare to access the CAQH record.

Are you individually accessible by appointment? ☐ Yes ☐ No

Board certified? ☐ Yes ☐ No Effective date:_/_/_____Expiration date:_/_/_____

Certification board: _____

Age restrictions:_____Gender restrictions: _____

Languages spoken: _____

*** SECTION L CONTINUES ON NEXT PAGE ***

Provider Information Update Form (PIF)

SECTION L (Provider joining a group/practice *continued)*

For Nurse Practitioners,Physician Assistants and nurse midwives only	Supervising physician name & degree:	Supervising physician NPI and specialty:

For additional questions, please visit Molinahealthcare.com, or call Provider Services at (800) 424-4524. Representatives are available to assist you Monday through Friday, from 8 a.m. to 6 p.m. ET.

Please email or fax this form and supporting documentation to:

Email: MCCVA-Provider@MolinaHealthcare.com

Fax: (888) 656-5098

Attachment D: Services Provided
Virginia

Provider/group name: _____

Group Tax ID Number: _____ Location NPI: _____

If completing services for individual practitioner/staff member, list:

Practitioner name: _____ Individual NPI: _____

General provider designation *(check all that apply, as licensed)*

☐ PCP (01)
☐ Pediatrician (02)
☐ OB-GYN (25)
☐ Specialist (03), list specialty: _____
☐ Health Department (04)
☐ Hospice (05)
☐ LTSS: Long Term Services and Supports* (06)
☐ Home Health (19)
☐ General Hospital (11)
☐ Physical Rehabilitation Hospital (12)
☐ Outpatient Rehabilitation (16)
☐ Radiology (18)
☐ RHC: Rural Health Clinic (28)
☐ FQHC: Federally Qualified Health Center (FQHC) (26)
☐ Other (24): Please describe _____

☐ Outpatient Mental Health—traditional services (07)
☐ ARTS: Addiction, Recovery and Treatment Services* (08)
☐ Mental Health Services* (09)
☐ Psychiatric Hospital* (10)
☐ CSB: Community Services Board* (27)
☐ Transportation (23)
☐ DME: Durable Medical Equipment and Supplies (17)
☐ Urgent Care (13)
☐ Nursing Facility (14)
☐ Vision (22)
☐ Laboratory (20)
☐ Pharmacy (21)

(For ARTS, Community Mental Health Services and LTSS, please also complete the appropriate sections below—<u>in addition to</u> General Provider Designation)*

Regions Served (Check all served by this Location NPI) ☐ Statewide
☐ Central ☐ Charlottesville/Western ☐ Northern/Winchester ☐ Roanoke/Alleghany ☐ Far Southwest ☐ Tidewater

LTSS: Long Term Services and Supports
Please complete this additional section, for all applicable LTSS services. For all services, provider(s) must also be licensedand approved by our credentialing department, prior to rendering these services to our members. In addition, ensure that an accompanying Provider Information Update Form is submitted for each location within your organization. (Please note LTSS service options continue onto next page.)

LTSS service	**Service indicator** *(for this NPI)*	**LTSS service**	**Service indicator** *(for this NPI)*
Adult Day Health Care (S5102)	☐ Yes ☐ No	Skilled Nursing Services (T1002/T1003)	☐ Yes ☐ No
Assistive Technology (T1999)	☐ Yes ☐ No	PERS: Installation/Monitoring (S5160/S5161)	☐ Yes ☐ No
Congregate Nursing Services (T1000/T1001)	☐ Yes ☐ No	PERS: Medication Monitoring (S5185)	☐ Yes ☐ No
Respite Care (T1005/S9125)	☐ Yes ☐ No	Personal Care (T1019)	☐ Yes ☐ No

Attachment D: Services Provided
Virginia

LTSS service	Service indicator *(for this NPI)*	LTSS service	Service indicator *(for this NPI)*
Congregate Respite Nursing (T1030/T1031)	☐ Yes ☐ No	PERS: Nursing Services (H2021)	☐ Yes ☐ No
Environmental Modifications (S5165/99199)	☐ Yes ☐ No	Transition Coordination (H2015)	☐ Yes ☐ No
Service Facilitation (Multiple Codes) *(example: 99509)*	☐ Yes ☐ No		

ARTS: Addiction, Recovery and Treatment Services

Please complete this additional section, for all applicable ARTS services. For all services, ensure you submit copies of required licenses and certifications, ARTS attestation(s), and ARTS roster(s). Provider(s) must also be approved by our credentialing department, prior to rendering these services to our members.

In addition, ensure that an accompanying Provider Information Update Form is submitted for each practitioner within your organization. (Please note ARTS service options continue onto next page.)

ARTS service	Service procedure code	Documentation required	Service indicator *(for location NPI above)*
ARTS Peer Support Services (Indv)	T1012	ARTS attestation and DBHDS license	☐ Yes ☐ No
ARTS Peer Support Services (Grp)	S9445	ARTS attestation and DBHDS license	☐ Yes ☐ No
Substance Use Case Management	H0006	ARTS attestation and DBHDS license	☐ Yes ☐ No
Substance Use Care Coordination	G9012	ARTS attestation and DBHDS license	☐ Yes ☐ No
Early Intervention Services/SBIRT ASAM 0.5	*Multiple*	ARTS attestation and DBHDS license	☐ Yes ☐ No
Office-Based Addiction Treatment (OBAT)	*Multiple*	ARTS attestation and DBHDS license	☐ Yes ☐ No
Opioid Treatment Services	*Multiple*	ARTS attestation and DBHDS license	☐ Yes ☐ No
Outpatient Services ASAM 1.0	*Multiple*	ARTS attestation and DBHDS license	☐ Yes ☐ No
Intensive Outpatient Services ASAM 2.1	H0015 or H0015 with rev 0906	ARTS attestation and DBHDS license	☐ Yes ☐ No
Partial Hospitalization Program ASAM 2.5	S0201 or S0201 with rev 0913	ARTS attestation and DBHDS license	☐ Yes ☐ No
Clinically Managed Low-Intensity Residential Services ASAM 3.1	H2034	ARTS attestation and DBHDS license	☐ Yes ☐ No
Clinically Managed Population-Specific High-Intensity Residential Services (Adults) ASAM 3.3	H0010, rev 1002 Modifier TG	ARTS attestation and DBHDS license	☐ Yes ☐ No
Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent) ASAM 3.5	H0010, rev 1002 Modifier-Adults HB, Adolescents HA	ARTS attestation and DBHDS license	☐ Yes ☐ No

Attachment D: Services Provided
Virginia

ARTS service	Service procedure code	Documentation required	Service indicator *(for location NPI above)*
Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent) ASAM 3.7	H2036, rev 1002 Modifier-Adults HB, Adolescents HA	ARTS attestation and DBHDS license	☐ Yes ☐ No
Medically Managed Intensive Inpatient ASAM 4.0	H0011, rev 1002	ARTS attestation and DBHDS license	☐ Yes ☐ No

Mental Health Services

Please complete this additional section, for all applicable mental health services. For all services, ensure you submit copies of required DBHDS licenses, and additional documentation, as noted below. Provider(s) must also be approved by our credentialing department, prior to rendering these services to our members.

In addition, ensure that an accompanying Provider Information Update Form, or Staff Roster, is submitted for each practitioner within your organization. (Please note Mental Health service options continue onto next page.)

Mental health service	Service procedure code	Documentation required	Service indicator *(for location NPI above)*
Peer Support Services	H0024/H0025		☐ Yes ☐ No
Applied Behavior Analysis (ABA)	97151-97158, 0362T, 0373T		☐ Yes ☐ No
Psychotherapy for Crisis	90839/90840		☐ Yes ☐ No
Functional Family Therapy (FFT)	H0036	MH Outpatient license from DBHDS; Certificate in FFT	☐ Yes ☐ No
Multisystemic Therapy (MST)	H2033	Intensive In-Home Services license from DBHDS; Certificate in MST	☐ Yes ☐ No
Community Stabilization	S9482	MH Crisis Stabilization (Non-Residential) license from DBHDS	☐ Yes ☐ No
Mobile Crisis Response	H2011	MH Crisis Stabilization (Non-Residential) license from DBHDS	☐ Yes ☐ No
23-Hour Crisis Stabilization	S9485	MH Crisis Stabilization (Non-Residential) license from DBHDS	☐ Yes ☐ No
Residential Crisis Stabilization	H2018	MH Crisis Stabilization (Non-Residential) license from DBHDS	☐ Yes ☐ No
Psychosocial Rehabilitation (PSR)	H2017	Psychosocial Rehab or Clubhouse Services license from DBHDS	☐ Yes ☐ No
Mental Health Skill-Building Services (MHSS)	H0046	Licensed by DBHDS as a provider of Supportive In-Home Services or Program of Assertive Community Treatment	☐ Yes ☐ No
Intensive In-Home (IIH)	H2012	Intensive In-Home Services license from DBHDS	☐ Yes ☐ No
Mental Health Case Management	H0023	CSB/Behavioral Health Authority (BHA) member; Case Management license from DBHDS	☐ Yes ☐ No
Therapeutic Day Treatment (TDT) - Non School Based	H2016 U7	Therapeutic Day Treatment Services license from DBHDS	☐ Yes ☐ No
Therapeutic Day Treatment (TDT) - School Based	H2016	Therapeutic Day Treatment Services license from DBHDS	☐ Yes ☐ No

Attachment D: Services Provided
Virginia

Mental health service	Service procedure code	Documentation required	Service indicator *(for location NPI above)*
Therapeutic Day Treatment (TDT) - After School	H2016 UG	Therapeutic Day Treatment Services license from DBHDS	☐ Yes ☐ No
Assertive Community Treatment (ACT) - Base Small Team	H0040 U2	Assertive Community Treatment license from DBHDS	☐ Yes ☐ No
Assertive Community Treatment (ACT) - Base Medium Team	H0040 U1	Assertive Community Treatment license from DBHDS	☐ Yes ☐ No
Assertive Community Treatment (ACT) - Base Large Team	H0040	Assertive Community Treatment license from DBHDS	☐ Yes ☐ No
Assertive Community Treatment (ACT) - High Fidelity Small Team	H0040 U5	Assertive Community Treatment license from DBHDS	☐ Yes ☐ No
Assertive Community Treatment (ACT) - High Fidelity Medium Team	H0040 U4	Assertive Community Treatment license from DBHDS	☐ Yes ☐ No
Assertive Community Treatment (ACT) - High Fidelity Large Team	H0040 U3	Assertive Community Treatment license from DBHDS	☐ Yes ☐ No
Mental Health Partial Hospital (MH-PHP) - Hospital Based Mental Health Program	H0035	MH-PHP license from DBHDS, Proof of Medicare enrollment as a Hospital, Staffing attestation	☐ Yes ☐ No
Mental Health Partial Hospital (MH-PHP) - Community Based Clinic Program	H0035	MH-PHP license from DBHDS, Proof of Medicare enrollment as a CMHC, Staffing attestation	☐ Yes ☐ No
Mental Health Intensive Outpatient Services (MH-IOP)	S9480	MH-IOP license from DBHDS, IOP Program Accreditation; Staffing attestation	☐ Yes ☐ No
MH-IOP with Occupational Therapy	S9480 GO	MH-IOP license from DBHDS, IOP Program Accreditation; Staffing attestation	☐ Yes ☐ No

All providers contracted and credentialed for the above services must be screened, enrolled (including signing a Department provider participation agreement), and periodically re-validated in the Department's Medicaid Enterprise System (MES) Provider Services Solution (PRSS), prior to contracting with Molina and maintaining participation in the Molina network. Providers must ensure appropriate staffing ratios, applicable supervision, and appropriate licensure, education and training. Failure to adhere to requirements and maintain PRSS enrollment, will result in termination from the network. By signing below, you agree to maintain compliance with requirements outlined by DMAS and Molina.

Authorized signatory (printed):_____

Authorized signatory (sign): _____

Email:_____Date signed:_____/___/_____

For additional questions, please visit Molinahealthcare.com, or call Provider Services at (800) 424-4524. Representatives are available to assist you Monday through Friday, from 8 a.m. to 6 p.m. ET.

Please email or fax this form and supporting documentation to:

Email: MCCVA-Provider@MolinaHealthcare.com

Fax: (888) 656-5098

Americans with Disabilities Act (ADA) Form: Virginia

Please complete the following attestation for each provider service location and return it with your signed contract.

Practice name:_____ Tax ID Number: _____

Service address:_____ Phone number: _____

Email address: _____

The Americans with Disabilities Act (ADA) requires providers make reasonable access and accommodations for all persons with disabilities. Molina Healthcare is providing you with the opportunity to self-attest to the below ADA standards, in order to verify core elements of ADA compliance, to service our members.

If you <u>are not</u> an office-based provider, please check here and proceed to the signature section below: ☐

If you <u>are</u> an office-based provider, please check complete each standard below, as applicable, and have the designated representative sign and return the attestation to Molina Healthcare.

ADA STANDARDS	RESPONSE
Building has handicap designated parking. Parking spaces are accessible with ramps and curb cutouts between the parking lot, office, and at drop-off locations.	☐ Yes ☐ No
Building has automatic entry option or alternative access method.	☐ Yes ☐ No
Building has elevator for public use (if building is multi-leveled). Elevator has enough room for the wheelchair and/or scooter to maneuver.	☐ Yes ☐ No
Restroom is equipped with large stall and safety bars or other reasonable accommodations.	☐ Yes ☐ No
Waiting room (including furniture) can accommodate patients with physical and non-physical disabilities. The reception and waiting areas have enough room for a wheelchair and/or scooter to maneuver and turn around.	☐ Yes ☐ No
At least one exam room can accommodate patients with physical and non-physical disabilities.	☐ Yes ☐ No
Signage and way finding is clear (e.g. color, symbol signage, and braille).	☐ Yes ☐ No
Doors to access building, office, and patient rooms are at least 32 inches wide.	☐ Yes ☐ No
The exam table moves up and down to make it easier to get on and off whether standing or using a wheelchair or scooter.	☐ Yes ☐ No
Diagnostic equipment can accommodate patients with disabilities.	☐ Yes ☐ No
The scale is able to accommodate a wheelchair or scooter.	☐ Yes ☐ No

Provider service locations that attest to being ADA compliant, or have received an in-office assessment and determined to be ADA compliant, will be published as such in our Provider Directory.

I attest to the best of my knowledge that the above information is true, accurate and complete.

Authorized signatory (printed):_____

Authorized signatory (sign): _____

Title:_____ Date signed:___/___/_____

Please email or fax this form and supporting documentation to:
Email: MCCVA-Provider@MolinaHealthcare.com Fax: (888) 656-5098

For additional questions, please visit our website at Molinahealthcare.com.