MOLINA

Provider Information Data Sheet

Group/Legal Name	
Due Date	
Return to	

Please fill this form out in its entirety per provider. Please put "N/A" if not applicable.

Section 1: Provider Information

Group Name/ Facility Name/ Legal Name:		
Last Name:	**First Name:**	**Middle Initial:**
DOB:	**SSN:**	
Provider Gender: ☐ **Male** ☐ **Female**	**Provider's Ethnicity:**	**Provider's NPI #**
CAQH #	**State License # / Effective & Term Date:**	**Highest Degree**
BCBA#	**Medicare Certified (if yes, CCN#)** ☐ **Yes CCN#** _____ ☐ **No**	
All Specialties:	**DEA # / Effective & Term Date:**	**Taxonomy Code(s):**

Billing/Mailing Address:	Billing Phone: Billing Fax:
Billing ID / TIN#	Billing NPI #
Email Address for Service Location:	Public Email Address:
Primary Servicing Address: (if different from Billing) *If more than one office, please attach roster of all locations* *(address, phone, fax and which providers go to which locations)*	Office Phone: Office Fax:

Office Hours:
Monday: From _____ To _____ **Tuesday:** From _____ To _____ **Wednesday:** From _____ To _____
Thursday: From _____ To _____ **Friday:** From _____ To _____ **Saturday:** From _____ To _____
Sunday: From _____ To _____

Specific Hours: *If any*

Provider's Language(s) Spoken:	Clinical Staff Language(s) Spoken:	Office Staff Language(s) spoken:

Qualified Medical Interpreter Language(s) (ICE Approved):

Exclusive Telehealth Provider? ☐ Yes ☐ No	"Physical' AND Telehealth Provider? ☐ Yes ☐ No
Accepting New Patients-Physical? ☐ Yes ☐ No	Accepting New Patients-Telehealth? ☐ Yes ☐ No
Age Restriction ☐ Yes From: ____ To: ____ ☐ No	Medical Board Certified Specialty ☐Yes #: _____ ☐ No If yes, specialty: _____

Gender Restriction ☐ Yes _____ ☐ No	CCS Paneled ☐ Yes ☐ No	CPSP Certified ☐ Yes ☐ No
CHDP Certified ☐ Yes ☐ No	FQHC Certified ☐ Yes ☐ No	Community Clinics ☐ Yes ☐ No

Traditional Provider? ☐ Yes ☐ No
(Any provider who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan.)

Section 2: For Provider's with Hospital Affiliations

Hospital Name 1:	Hospital Admitting Privilege (s) 1 ☐ Admitting ☐ Consulting ☐ Provisional ☐ Teaching Hosp
Hospital Name 2:	Hospital Admitting Privilege (s) 2 ☐ Admitting ☐ Consulting ☐ Provisional ☐ Teaching Hosp
Hospital Name 3:	Hospital Admitting Privilege (s) 3 ☐ Admitting ☐ Consulting ☐ Provisional ☐ Teaching Hosp
Hospital Name 3:	Hospital Admitting Privilege (s) 3 ☐ Admitting ☐ Consulting ☐ Provisional ☐ Teaching Hosp

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Please fill this form out in its entirety per provider. Please put "N/A" if not applicable.

I hereby affirm that the information submitted in this Provider Data form is current, correct, and complete to the best of my knowledge and belief in good faith.

Print Name: _____ **Signature:** _____ **Date:** _____

Section 3: For Ancillary & Hospital Providers

Please Mark all that applies:

☐ California Children Services (CCS) ☐ JCAHO ☐ Teaching Hospital ☐ Tertiary Hospital

Section 3a: For Skilled Nursing Facilities

Subacute: ☐ Yes ☐ No (*Skilled only*)	Number of Beds:
Levels of Care available at Facility:	
Dialysis: ☐ Yes ☐ No	Bariatric: ☐ Yes ☐ No

Section 4: For Direct Primary Care Physicians making rounds at Skilled Nursing Facilities:

Only Seeing Established Custodial Patients:	☐Yes ☐ No
Only Seeing Established Skilled Patients:	☐Yes ☐ No
Open to accept Established Patients that are now Custodial:	☐Yes ☐ No
Open to accept new Custodial Patients: *(That have never been seen by or assigned to me before)*	☐Yes ☐ No

I make rounds at the following Skilled Nursing Facilities:

(If more than 20 please attach a separate list)

1)	11)
2)	12)
3)	13)
4)	14)
5)	15)
6)	16)
7)	17)
8)	18)
9)	19)
10)	20)

I hereby affirm that the information submitted in this Provider Data form is current, correct, and complete to the best of my knowledge and belief in good faith.

Print Name: _____ **Signature:** _____ **Date:** _____

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Section 5: For Behavioral Health Providers Only

1	Individual/Group Mental Health Evaluation and Treatment (Psychotherapy)?	☐ Yes ☐ No	16	Trauma and Stressor-Related Disorders?	☐ Yes ☐ No
2	Psychological Testing when Clinically Indicated to Evaluate a Mental Health Condition?	☐ Yes ☐ No	17	Dissociative Disorders?	☐ Yes ☐ No
3	Comprehensive Diagnostic Evaluation for ASD (ADOS, ADI)?	☐ Yes ☐ No	18	Sexual Dysfunctions?	☐ Yes ☐ No
4	Psychiatric Consultation for Medication Management?	☐ Yes ☐ No	19	Gender Dysphoria?	☐ Yes ☐ No
5	Screening and Brief Intervention (SBI)?	☐ Yes ☐ No	20	Feeding and Eating Disorders?	☐ Yes ☐ No
6	Neurodevelopmental Disorders?	☐ Yes ☐ No	21	Elimination Disorders?	☐ Yes ☐ No
7	ABA Behavioral Health Therapy	☐ Yes ☐ No	22	Sleep-Wake Disorders?	☐ Yes ☐ No
8	Neurocognitive Disorders?	☐ Yes ☐ No	23	Disruptive, Impulse-Control, and Conduct Disorders?	☐ Yes ☐ No
9	Substance-Related and Addictive Disorders?	☐ Yes ☐ No	24	Personality Disorders?	☐ Yes ☐ No
10	Schizophrenia Spectrum and Other Psychotic Disorders?	☐ Yes ☐ No	25	Paraphilic Disorders?	☐ Yes ☐ No
11	Bipolar and Related Disorders?	☐ Yes ☐ No	26	Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized?	☐ Yes ☐ No
12	Depressive Disorders?	☐ Yes ☐ No	27	Bariatric Counseling Services?	☐ Yes ☐ No
13	Anxiety Disorders?	☐ Yes ☐ No	28	Other Areas of Expertise:	
14	Obsessive-Compulsive and Related Disorders?	☐ Yes ☐ No	29	Please list billing codes used most often:	
15	Somatic Symptom and Related Disorders?	☐ Yes ☐ No			

Section 6: For Behavioral Health Therapy Providers Only

1	Perform Comprehensive Diagnosis Evaluations?	☐ Yes ☐ No
2	Number of providers in your group/agency by QAS level: **QASP:** **QASPRO:** **QASPARA:** **TOTAL:**	
3	Qualifications of staff:	
4	Training provided to staff:	
5	Demographics/Service Area(s):	

Section 6a: Experience with the following behaviors/intervention areas:

1	Non-compliance	☐ Yes ☐ No	10	Self-Help Skills	☐ Yes ☐ No
2	Physical Aggression	☐ Yes ☐ No	11	Self-Direction	☐ Yes ☐ No
3	Verbal Aggression	☐ Yes ☐ No	12	Social Skills	☐ Yes ☐ No
4	Outbursts	☐ Yes ☐ No	13	Hygiene	☐ Yes ☐ No
5	Property Destruction	☐ Yes ☐ No	14	Toilet Training	☐ Yes ☐ No
6	Self-Injury	☐ Yes ☐ No	15	Independent Living Skills	☐ Yes ☐ No
7	Elopement	☐ Yes ☐ No	16	Safety Awareness	☐ Yes ☐ No
8	Stereotypic behavior	☐ Yes ☐ No	17	Food Selectivity	☐ Yes ☐ No
9	Functional Communication	☐ Yes ☐ No	18	Other:	☐ Yes ☐ No

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Print Name: _____ **Signature:** _____ **Date:** _____