Provider Application - Pharmacist

Thank you for your interest in becoming a United Healthcare Provider! Please complete the following information and submit to uhccsohpharmacist@uhc.com

Please note: In order for providers to contract with a Medicaid managed care plan, the Ohio Department of Medicaid requires all providers to be enrolled with Ohio Medicaid at both the practice/facility and individual provider levels, as applicable.

Pharmacist Information		
Name of Applicant Last	First	Middle
Address of Applicant Address and street or rural route	City	
State:	Zip Code:	County:
Telephone number: (daytime)	E-mail address:	
Gender: F M Undisclosed	Date of Birth: (MM/DD/YYYY)	SSN: (This must be your personal SSN even if you are enrolling or revalidating)
License Number:	License Type:	
License Issue Date: (MM/DD/YYY)	License Expiration Date: (MM/DD/YYYY)	Title/Degree: (As appears on license)
National Provider Identifier (NPI):	NPI verified: Y N	
Ohio Medicaid Provider Number:	Certification Number:	
Location of Employment: Address and street or rural route:	City:	
State:	Zip Code:	County:
Collaborative Practice Agreements: (Please initial in box) Applicant attests to have active Collaborative Practice Agreements with eligible practitioners following O.A.C. 4729:1, O.R.C. 4729.39.		

Applicant Signature: ____ Date: ____________________

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