MOLINA HEALTHCARE

PROVIDER CHANGE FORM Today's Date: _____/_____/_____

CURRENT PRACTICE INFORMATION

ALL FIELDS IN THIS SECTION ARE REQUIRED

Type of Provider: Ancillary ☐ Specialist ☐ Primary Care Provider ☐ Hospital ☐ Urgent Care ☐

Type 1 (Individual) NPI: ☐☐☐☐☐☐☐☐☐☐ Type 2 (Group) NPI ☐☐☐☐☐☐☐☐☐☐

Provider Name: _____ Group Name: _____

Tax ID: ☐☐- ☐☐☐☐☐☐☐

Contact Person: _____ Phone # (_____)_____

Requested Effective date of change: _____

Authorizing signature: _____ Authorizing signature printed:_____

(*Physician/Office Manager signature required)*

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION - Your request will be processed for all participating lines of business. Changes will be effective within 60 days. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 form with this change form. Please check the changes you are requesting.

PLEASE PRINT OR TYPE

☐ **Adding a Practice Address** ☐ **Deleting a Practice Address** ☐ **Billing Address Change*** ☐ **Telephone/Fax Change** ☐ **Office Hours Change**
☐ **Include in Provider Directory** ☐ **Exclude from Provider Directory** ☐ **Correct a Practice Address**

Street: _____City:_____State:_____ Zip: _____
Phone: (_____)_____ Fax: (_____)_____ Office Hours:

☐ **Tax ID Change ***

New Tax ID: ☐☐- ☐☐☐☐☐☐☐

☐ **Termination from Molina Healthcare Inc.**

Explanation/reason for termination: _____
If a PCP, who will be assuming your patient panel *(Last Name, First Name)* :_____

☐ **Add Hospital Affiliation** ☐ **Delete Hospital Affiliation**

Hospital Name: _____

☐ **Panel Update**

☐ Close panel to all new members, but keep existing panel ☐ Open panel to all members
☐ Close panel to all members (new and existing) and reassign them to the following physician: _____
(Last Name, First Name)

☐ **Add a** ☐ **Primary/** ☐ **Secondary (*indicate one*) specialty** ☐ **Remove a** ☐ **Primary /** ☐ **Secondary *(indicate one)* specialty**

Specialty Name: _____ Taxonomy Code: _____

☐ **Name Change Only ***

Current Name: _____ New Name: _____

☐ **Change of Ownership ***

_____ Effective date of ownership: _____ /_____/_____
Legal Business Name of New Owner and Federal Tax ID

☐ **Add a Covering Provider** ☐ **Remove a Covering Provider**

Provider Name _____ End date of Coverage (if applicable) _____ /_____/_____

Please mail, fax or email this change form *and* supporting documentation to:
Systems Configuration, Molina Healthcare of Michigan, 100 W Big Beaver Rd Ste 600, Troy, MI 48084; Fax (248) 925 – 1757
MHMProviderChangeForm@molinahealthcare.com
For Questions, please call the Provider Call Center at (888)898-7969, Option 1

*Indicates that a W-9 form is required with submission