



Provider Information Update Form

This form is used to notify Molina Healthcare of Ohio, Inc. of any changes to your practice information.
This form may also be found online at www.MolinaHealthcare.com.

CURRENT PRACTICE INFORMATION

Provider Last Name: _____	First Name: _____	Middle Initial: _____
Practice/Group Name: _____		
Group Medicaid Number: _____	Provider Medicaid Number: _____	
Provider NPI Number: _____	Provider Medicare Number: _____	
Current Provider/Practice Tax ID Number: _____		

Please provide the information on the changes to be made to the practice information:

TAX ID CHANGE

New Tax ID number: _____
<ul style="list-style-type: none"> To change your Tax ID in our system, a copy of your W-9 is required. Please attach the W-9 with this form.

ADDRESS CHANGE

Service location(s) changed effective: ____/____/____	
<ul style="list-style-type: none"> To change or update the service location address in Molina's system, a new ODJFS Attachment B for PCPs and an ODJFS Attachment C for Specialists and Ancillaries affected by this change is required. 	
New Address/Phone Number	Previous Address/Phone Number
Address 1:	Address 1:
Address 2:	Address 2:
City, State Zip:	City, State Zip:
Phone Number: ()	Phone Number: ()

BILLING ADDRESS CHANGE

Billing address changed effective: ____/____/____	
New Billing Address/Phone Number	Previous Billing Address/Phone Number
Billing Contact:	Billing Contact:
Address 1:	Address 1:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
Phone Number: ()	Phone Number: ()

PRACTICE NAME CHANGE

Practice name changed effective: ____/____/____	
<ul style="list-style-type: none">• A copy of a W-9 is required to change the group practice name in Molina's system. Please attach the W-9 with this form.• To change or update the service location address in Molina's system, a new ODJFS Attachment B for PCPs and an ODJFS Attachment C for Specialists and Ancillaries affected by this change is required.	
New Practice Name	Previous Practice Name
New Practice Name:	Previous Practice Name:
Medicaid Number:	Medicaid Number:

PROVIDER JOINING GROUP

The following provider has been added to this practice:		
<ul style="list-style-type: none">• To add a provider to your practice, an ODJFS Attachment B for PCPs and an ODJFS Attachment C for Specialists and Ancillaries is required.		
New Provider Information		
Provider Last Name:	First Name:	Middle Initial:
Provider Type: (MD, DO, DC, DDS, DPM, etc.)	Last 4 Digits of SS #:	Medicaid Number:
Group Name:	CAQH Number:	
Effective: ____/____/____	NPI Number:	

PROVIDER TERMING FROM GROUP (Attach termination letter to this form and return)

Please attach a letter on the company's letterhead including:
<ul style="list-style-type: none">• Name of provider to be termed• Group name• Effective date of termination• Reason for termination• Address(es) of practice location(s) effected by termination

Name of individual completing this form (Please Print): _____

Signature of individual completing this form: _____

Phone Number: (____) _____ Date: ____/____/____

If you have any questions or concerns, please visit Molina's website at www.MolinaHealthcare.com, or call the Provider Services Department at 1-800-642-4168. A representative will be available to assist you from 8:00 a.m. – 5:00 p.m., Monday through Friday.

Please Mail or Fax the completed form to:

Molina Healthcare of Ohio, Inc.
Attn: PIM
P.O. Box 349020
Columbus, OH 43234-9020
Fax Number: (614) 781-1537