



Provider Change of Information Form

Provider Type:	<input type="checkbox"/> PCP	<input type="checkbox"/> SPECIALIST	<input type="checkbox"/> LTSS	<input type="checkbox"/> ANCILLARY	<input type="checkbox"/> FACILITY
Name:					
Specialty:					
Provider NPI:		Provider TPI:		Provider Group NPI:	
Tax ID:		THSteps TPI:			
Please check Information requiring Change:					
<input type="checkbox"/> Change of Office Address <input type="checkbox"/> Change of Mailing Address <input type="checkbox"/> Addition of New Location <input type="checkbox"/> Opening Panel <input type="checkbox"/> Closing Panel <input type="checkbox"/> Other _____					
Current Information (Include phone number)			New/Updated Information (Include phone number)		
Provider Comments *					

Provider Termination

- Moved out-of-State
- Retired
- Voluntary term request by provider
- Deceased
- Other _____

- Termed with the Medical Group* Termed with the Delegated IPA *

*If provider has termed with Group or IPA and provider remains directly contracted with Molina Healthcare, please complete updated information on front page of this form.

Print name and title of Authorized Personnel: _____

Signature of Authorized Personnel (Require to make change) _____

***Please attach a separate piece of paper if necessary. Thank you for your cooperation.**

Submit change of information form and an updated W-9 to the Provider Contracting Department within 30 days of the event triggering the reporting obligation. Form may be faxed or emailed to the following:

Fax: (877) 319-6851

Email: mhtcontracting@molinahealthcare.com