



# 5010 PROVIDER CHANGE FORM

Today's Date: \_\_\_/\_\_\_/\_\_\_

## CURRENT PRACTICE INFORMATION ALL FIELDS IN FIRST SECTION ARE REQUIRED

Provider Name: \_\_\_\_\_

Group Name (if applicable): \_\_\_\_\_

Tax ID:   -

TPI #: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone # (\_\_\_\_\_) \_\_\_\_\_

Authorizing signature: \_\_\_\_\_

Authorizing name printed: \_\_\_\_\_

*(Physician/Office Manager signature required; email signature okay)*

## PROVIDER CHANGE INFORMATION

**PROVIDE COMPLETE INFORMATION** - Your request will be processed for all participating lines of business.

### PLEASE PRINT OR TYPE

#### Provider Group Will Be Changing to Subpart Billing: Yes or No

Date Billing Will Change to Subparts: (before 1/1/2012 requested) \_\_\_\_\_

Subpart Billing Name -1: \_\_\_\_\_

Subpart Billing NPI - 1: \_\_\_\_\_

Street Address that will be submitted on claim form:

\_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Remit Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Rendering Providers at Subpart Billing Name1: \_\_\_\_\_

Subpart Billing Name -2: \_\_\_\_\_

Subpart Billing NPI -2: \_\_\_\_\_

Street Address that will be submitted on claim form:

\_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Remit Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Rendering Providers at Subpart Billing Name2: \_\_\_\_\_

For more than 2 subparts, attach additional pages.

**Please email or fax this change form *and* supporting documentation to:**

**[TX.PSV@molinahealthcare.com](mailto:TX.PSV@molinahealthcare.com) / 1-877-319-6854**