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:

☐ **INDIVIDUAL NAME CHANGE**

New Last Name:_____ New First Name: _____ Middle Initial: _____

- *An updated ODJFS Attachment A for PCPs and an ODJFS Attachment B for Specialists is required for all practices/groups affected by this change.*

☐ **ADDING NEW GROUP TO SAME TIN**

New Group Name:_____

- *To change your group name in our system, please complete this form and include a W-9.*

☐ **TAX ID CHANGE**

New Tax ID number:_____

- *To change your Tax ID in our system, please complete this form and include a W-9.*

☐ **ADDRESS CHANGE**

Service location(s) changed effective: ____/____/____

- *To change a service location or add an address in Molina's system,* ***a new ODJFS Attachment A for PCPs and an ODJFS Attachment B 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: ( )
Fax Number: ( )	Fax Number: ( )

☐ PAY TO ADDRESS CHANGE

Pay To address changed effective: ____/____/____

New Pay To Address/Phone Number	Previous Pay To Address/Phone Number
Pay To Contact:	Pay To Contact:
Address 1:	Address 1:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
Phone Number: ( )	Phone Number: ( )
Fax Number: ( )	Fax Number: ( )

☐ PRACTICE NAME CHANGE

Practice name changed effective: ____/____/____

- *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 A for PCPs and an ODJFS Attachment B 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

- *To add a provider to your practice, please complete this form and include an **ODJFS Attachment A for PCPs and an ODJFS Attachment B for Specialists and Ancillaries** as this is required.*

☐ PROVIDER NEEDS CREDENTIALED

- *To submit credentialing information please complete page 3, CAQH Provider Data Form.*

☐ PROVIDER TERMING FROM GROUP - Note: Notice required per termination language stated in contract.

Please complete this form and attach a letter on the company's letterhead including:

• *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): _____

Phone Number: (____) _____ Fax Number: (____) _____

Email: _____ Date: ____/____/____

If you have any questions or concerns, please visit Molina's website at www.MolinaHealthcare.com, or call the Provider Services Department at 1-800-357-0146. A representative will be available to assist you from 8 a.m. - 5 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

Molina Healthcare of Ohio CAQH Provider Data Form for Credentialing Purposes

Ohio Revised Code 3963.05 prescribes the credentialing form used by the Council for Affordable Quality Healthcare (CAQH) as the required credentialing application for physicians.

If you participate in CAQH:
To begin the Credentialing process, please complete this CAQH Provider Data Form and submit it to Molina Healthcare of Ohio, Inc.

If you are not participating in CAQH:
Please complete this CAQH Provider Data Form and return it to Provider Information Management at Molina Healthcare of Ohio, Inc. A CAQH number will be generated, and your office will be notified. **Once you receive your CAQH number, it is your responsibility to complete the on-line CAQH Provider Application and include all appropriate documents and notify Molina.** You may access the CAQH website at www.caqh.org. Click on Providers UPD Login and Information, and follow the first time log-in instructions.

The CAQH Support Desk can be reached directly at 1-888-599-1771 to assist in the resolution of any issues regarding CAQH participation.

Last Name:	First Name:		Middle Initial:
Provider Type: (MD, DO, DC, DDS, DMD, DPM, etc.)	Last 4 digits of Provider SS#:	Provider NPI#:	
Date of Birth: _____/_____/_____	E-Mail Address:		
Primary Telephone Number:( )	Primary Fax Number:( )		
Group Name:			
Primary Office Street Address:			Suite#:
Primary Office City:	State:	County:	Zip:
Specialty:	Applying as: ☐ PCP ☐ Specialist ☐ Allied Health Professional		
Are you board certified? ☐ Yes ☐ No	If Yes, board name:		
Are you registered with CAQH? ☐ Yes ☐ No	If Yes, CAQH Provider ID:		
Authorized Signature:	**Date Signed:**		

Please fax to 1-614-781-1537 or mail to the address below to Attn: PIM.

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing Data Source does not constitute applying for participation with any healthcare organization. If applicable, please contact the health plan directly to request contracting information. Please make sure that your CAQH information is updated and completed.