

MICHIGAN PROVIDER CHANGE FORM

Please mail, fax or email this change form and supporting documents to:

Molina Healthcare of Michigan, 880 West Long Lake Road, Suite 600, Troy, MI 48098; Fax (248) 925-1757

Email MHMContractConfigDept@MolinaHealthCare.com

For Questions, please call the Provider Call Center at (855) 322-4077

Group Name:		Group NPI:	
Physician Name(s):		Individual NPI:	
Tax ID:	Today's Date:		Effective date of change:
Type of Provider: ☐ PCP ☐ SPC ☐ ANCILLARY ☐ HOSPITAL ☐ URGENT CARE ☐ FQHC/RHC/THC ☐ Dental/Dentist			
Authorized Submitter: (please print):		Title:	
Email Address: □ Please check here to receive health plan updates via email		Group Website:	
Type of Change: ☐ Demographic ☐ Office Hours ☐ Hospital Affiliation ☐ Include in Directory ☐ Exclude from Directory ☐ Specialty Update ☐ *Tax ID Change A change in ownership may require a new contract, please email our Provider Contracting Department at MHMProviderContractingMailbox@Molinahealthcare.com ☐ Voluntary Termination ☐ Involuntary Termination Reason:			
Panel Update: Open panel to all members (If you're requesting any other panel updates please contact your Provider Service Representative)			
Molina Product: ☐ Medicaid ☐ Medicare ☐ Marketplace ☐ MI Health Link (MMP)			
Comments/Other (please list any details regarding your request here):			
Provider Demographic Change Information If the requested change affects multiple providers or service locations please include a separate roster with the additional information			
Service Location Name	Current Information		Requested Change
☐ Check here if this is an additional location☐ Check here if you are removing this location			
Address 1			
Address 2			
City, State Zip			
Contact Numbers Phone:			Phone:
	Fax:		Fax:
*Pay to/Mailing	Current Info	rmation	Requested Change
Address 1			
Address 2			
City, State Zip			
Contact Numbers			
Tax ID			
PCMH Certification (submit certification)	Effective Date:		Term Date:
Internal Use Only: Add a Network Remove Rem			
Membership Moves Reassignment for Terminated Providers			
SUBJECT TO REVIEW BASED ON CONTRACT	From	1	То
Physician Name			
NPI			
Specialty			
Pay To Name			
Service Location Name			
Address			
Address 2 (if applicable)			
City, State Zip			

^{*} Indicates that a W-9 form is required with submission (W-9 information must match your IRS documentation)