Provider Information Update Form

Use this form to notify Molina Healthcare of Wisconsin of any changes to your practice information. This form is also available at MolinaHealthcare.com.

CURRENT PRACTICE INFORMATION

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

Provide information on practice changes to be made:

☐ INDIVIDUAL NAME CHANGE

New Last Name:	New First Name:	Middle Initial:

An updated Provider Roster is required for all practices/groups affected by this change.

☐ ADDING NEW GROUP TO SAME TIN

New Group Name:
New NPI:

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

Remittance Address	Physical Address
Address 1:	Address 1:
Address 2:	Address 2:
City, State, ZIP:	City, State, ZIP:
Effective Date: / /	

☐ TAX ID CHANGE

New Tax ID number:

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

Remittance Address	Physical Address
Address 1:	Address 1:
Address 2:	Address 2:
City, State, ZIP:	City, State, ZIP:
Effective Date: / /	

☐ ADDRESS CHANGE – SERVICE LOCATION

Service location(s) changed effective: / /	Check one: ☐ Current Location Update ☐ Additional/New Location

To change a service location or add an address in the Molina Healthcare system, a new Provider Roster is required for all providers affected by this change.

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:

☐ ADDRESS CHANGE – PAY-TO

Pay-To address changed effective: / /

To change your Pay-To address in our system, please complete this form and include a Form W-9.

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 Form W-9 is required to change the group practice name in the Molina system. Attach Form W-9 with this form.
- To change the practice name in Molina Healthcare's system, a new Provider Roster is required for all providers affected by this change.

New Practice Name	Previous Practice Name
New Practice Name:	Previous Practice Name:
Medicaid Number:	Medicaid Number:

☐ PROVIDER JOINING GROUP

To add providers to your practice, complete this form and include a Provider Roster, in an Excel spreadsheet, for all new providers joining the group. The roster must be completed in full, including but not limited to: Accepting New Patients, Practice As (PCP, SPEC, etc.), Effective Date, and Provider (s) Location and List in Provider Directory.

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☐ PROVIDER NEEDS CREDENTIALING

To submit credentialing information, complete, **CAQH Checklist**.

☐ 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) affected by termination

☐ ADDITIONAL COMMENTS

List other demographic or provider data updates needed at this time.

Name of individual completing this form (Please Print):	
Phone Number:	Fax Number:
Date: / /	Email:

Email the completed form and all other materials to:
MHWIProviderNetworkManagement@MolinaHealthcare.com