MOLINA HEALTHCARE

Date: _____ / _____ / _____

PROVIDER INFORMATION CHANGE FORM

Please fax or email this change form and supporting documentation to:
MHT Provider Services at (877) 900-8452 or MHTXProviderServices@MolinaHealthCare.Com

CURRENT PRACTICE INFORMATION

ALL FIELDS IN THIS SECTION ARE REQUIRED
Please Print or Type

Type of Provider: Ancillary ☐ Specialist ☐ Primary Care Provider ☐ LTSS ☐ Hospital ☐ Urgent Care ☐

Type 1 (Individual) NPI: _____

Type 2 (Group) NPI: _____

Provider Name: _____

Group Name: _____

Tax ID: _____

Phone #: (_____) _____

Street: _____

City: _____

State: _____ Zip: _____

Email: _____

Contact Person: _____

Fax #: _____

Authorizing Signature: _____
(Physician/Office Manager Signature Required)

Requested Effective Date of Change: _____

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – Your request will be processed for all participating lines of business. Changes will be effective within 30 days. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 form with this change form. Please check the changes you are requesting.

PLEASE PRINT OR TYPE

Add a Practice Address ☐ Deleting a Practice Address ☐ Add to Provider Directory ☐ Remove from Provider Directory ☐

Address to be added or deleted:

Street: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Fax: (_____) _____ Office Hours:

Billing Address Change* ☐ Telephone/Fax Change ☐ Office Hours Change ☐ Correct Practice Address ☐
Include in Provider Directory ☐ Exclude from Provider Directory ☐

Updated Information:

Street: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Fax: (_____) _____ Office Hours:

Tax ID Change* ☐

To update your Tax ID, please email MHTContractRequest@MolinaHealthcare.com.

Add Hospital Affiliation ☐ Delete Hospital Affiliation ☐

Hospital Name: _____

Panel Update ☐

Close Panel to all new members, but keep existing panel ☐ Open panel to all new members ☐
Close Panel to all members (new and existing) and reassign them to the follow physician: _____
(Last name, First Name)

Reason (Required): _____

Add a Primary Specialty ☐ Add a Secondary Specialty ☐ Remove a Primary Specialty ☐ Remove a Secondary Specialty ☐

Specialty Name: _____ Taxonomy Code: _____

Name Change Only* ☐

Current Name: _____ New Name: _____

Change of Ownership* ☐

Legal Name of New Owner and Federal Tax ID: _____

Effective Date of Ownership: _____ /_____ /_____

Add a Covering Provider ☐ Remove a Covering Provider ☐

Provider Name:_____ End Date of Coverage (if applicable): _____/_____/_____

ADDITIONAL I NFORMATION	SERVICES
Languages Spoken other than English: _____ _____ _____ _____ Indicate Office Hours, including evenings and weekends: _____ _____ _____ _____ Patient Age Range Accepted by Provider:_____ _____	Please check off the below services that you offer: ☐ Pediatric Services ☐ Intellectual Disability Development ☐ Mental Health Rehabilitation Services ☐ Mental Health Targeted Case Management ☐ Telemedicine ☐ Telehealth ☐ Telemonitoring ☐ SE – Supported Employment ☐ EA – Employment Assistance ☐ Financial Management Services (CDS) ☐ Mobile Provider ☐ Public Transportation Accessible

Comments: _____

_____

_____

_____

*Indicates that a W-9 form is required with submission