Provider Information Update Form

This form is used to notify Molina Healthcare of Wisconsin of any changes to your practice information.

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:

☐ PCP/Panel/Directory Flag Update

☐ PCP ☐ Accepting New Members ☐ Include in Provider Directory

Service locations affected by this change:_____

- *If multiple service locations affected please attach list of service locations.*

☐ 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:_____

- *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: ____/____/____ Check one: ☐ New Location ☐ Additional Location

- *To change a service location or add an address in Molina Healthcare's 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: ( )

☐ PAY TO ADDRESS CHANGE

Pay To address changed effective: ____/____/____ - an updated W-9 is also required to update your pay to address.

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 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 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: ____/____/____

Please send the completed form to: Email: mhwiprovider.services@molinahealthcare.com