

ACTION	You will need to complete the sections identified below on the provider information update form (pif) and any additional documents listed. All documents must be completed and returned
Add a Provider to the group	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A, Section N*</b></li> <li>*<b>Section N</b> can be copied when adding multiple providers</li> </ul>
Termining a provider	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section J</b></li> <li>Term letter on your organization's letterhead</li> </ul>
Closing a service location(s)	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section H</b></li> </ul>
Change Phone/Fax	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A, Section F</b></li> </ul>
Change the Pay-To/ Billing Address	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section I</b></li> <li><b>W-9</b></li> <li>Sample Claim Form (de-identified)</li> </ul>
Change or add a service location	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A, Section G</b></li> </ul>
Add a new group to the same Tax Identification Number (TIN)	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b></li> <li><b>W-9</b></li> <li>Sample Claim Form (de-identified)</li> </ul>
Change Group Name Only	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section D</b></li> <li>Sample Claim Form (de-identified)</li> <li><b>W-9</b></li> </ul>
Change TIN only	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section B</b></li> <li><b>W-9</b></li> <li>Sample Claim Form (de-identified)</li> </ul>
Individual Name Change	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section E</b></li> </ul>
Provider Directory Update	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section L</b></li> </ul>
Panel Update	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section K</b></li> </ul>
Hospital Affiliations Update	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section M</b></li> </ul>
Group/Provider NPI change	<ul style="list-style-type: none"> <li>PIF – Complete <b>Section A</b> and <b>Section C</b></li> </ul>

FORMS:	FORM USAGE:
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare.
<b>W-9</b>	This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name, and Tax ID when received with a <b>PIF</b> .
Credentialing - Individual Providers	YOU WILL NEED TO...
If you have a CAQH number	Complete CAQH Provider Data Form. You also need to update and give Molina Healthcare permission to review. Visit the website at <a href="http://caqh.org">caqh.org</a> .
If you do not have a CAQH number	Go to <a href="http://caqh.org">caqh.org</a> to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review.
Credentialing - Facilities and Other Providers	YOU WILL NEED TO ...
Including Hospitals, Ambulatory Surgical Centers, Home Health Agencies, Durable Medical Equipment (DME) Suppliers, SNFs, Urgent Care Centers, and Retail Clinics	<p>Print, complete, fax, email or mail the <b>Healthcare Delivery Organization Form</b>.</p> <p>This form can be found on our website at <a href="http://MolinaHealthcare.com/providers">MolinaHealthcare.com/providers</a></p> <p>Molina Healthcare of Mississippi            Attention: Provider Contracts            188 E. Capitol Street, Suite 700            Jackson, MS 39201</p> <p>Email: <a href="mailto:MHMSProviderContracting@MolinaHealthcare.com">MHMSProviderContracting@MolinaHealthcare.com</a></p>
CONTACT INFORMATION	If you have additional questions please contact Molina Healthcare's Provider Services department at (844) 826-4335 between the hours of 7:30 a.m. to 6 p.m. CST, Monday through Friday.

## Provider Information Update Form (PIF)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

This form and the associated documentation are required to notify Molina Healthcare of Mississippi of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at [MolinaHealthcare.com](https://MolinaHealthcare.com).

Type of Group: ☐ Medical Group ☐ Specialist ☐ PCP ☐ Hospital ☐ Urgent Care  
☐ FQHC/RHC ☐ Behavioral Health ☐ PHO-IPA ☐ ASC ☐ Other

### SECTION A

#### Current Group/Practice Information *(All fields in this section are required)*

Group/Practice Name: \_\_\_\_\_

Group/Practice Tax ID: \_\_\_\_\_ Group/Practice Medicaid #: \_\_\_\_\_

Group/Practice NPI #: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Email address: \_\_\_\_\_ Contact Name: \_\_\_\_\_

#### Group/Practice Add, Name Change, Tax ID Number Change and NPI Change

If changing both the Group/Practice Name and the Tax ID Number, a new contract is required.  
Please contact Molina Healthcare Provider Services at (844) 826-4335. A representative will be available to assist you Monday through Friday, 8 a.m. - 5 p.m EST.

### SECTION B

**Tax ID Number Change** Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Tax ID Number \_\_\_\_\_ New Tax ID Number \_\_\_\_\_

### SECTION C

#### Group/Provider NPI Change

☐ **Group** ☐ **Individual**

Group/Provider Name: \_\_\_\_\_

Previous NPI: \_\_\_\_\_ New NPI: \_\_\_\_\_

## SECTION D

### Group/Practice Add or Change

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Group/Practice name: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

New Group/Practice name: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

## OTHER CHANGES

## SECTION E

### Individual Name Change

Previous Name: \_\_\_\_\_ New Name: \_\_\_\_\_

## SECTION F

### Change Phone/Fax

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Phone Number: \_\_\_\_\_ New Phone Number: \_\_\_\_\_

Previous Fax Number: \_\_\_\_\_ New Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## SECTION G

☐ **Add a Service Location** ☐ **Change a Service Location** Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Previous Address

### New Address

Address 1: \_\_\_\_\_ Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

## SECTION H

☐ **Closing a Service Location**

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Reason: (Required) \_\_\_\_\_

Authorizing Signature Printed: \_\_\_\_\_

Authorizing Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION I

**Billing Address Change**

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Previous Billing Information**

**New Billing Information**

Billing Contact: \_\_\_\_\_ Billing Contact: \_\_\_\_\_

Address 1: \_\_\_\_\_ Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

- Is this a Notice Address Change? ☐ No ☐ Yes

*The notice Address is the particular party's address for delivery or mailing of notice purposes.*

## SECTION J

### Terminating a Provider

A termination letter is required on company letterhead including: name of the provider to be termed, group name, effective date of termination, reason for termination and address of practice location(s).

If terminating provider is a PCP, who will assume patient panel?

Provider Name (Last, First, MI) \_\_\_\_\_

## SECTION K

### Panel Update

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Existing Patients Only

☐ Close Panel to all Members

☐ Open Panel

Reason: (Required) \_\_\_\_\_

## SECTION L

### Provider Directory Update

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Include in Provider Directory

☐ Exclude from Provider Directory

Reason: (Required) \_\_\_\_\_

## SECTION M

### Hospital Affiliations Update

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Add Hospital Affiliation(s)

☐ Remove Hospital Affiliation(s)

Names of Hospital(s) \_\_\_\_\_

## SECTION N

### Provider Joining a Group/Practice

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Locum Tenen: ☐ Y ☐ N

Provider Name (Last, First, MI): \_\_\_\_\_

Provider Type (MD, DO, DDS, NP, PA, etc.): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Note:** If the provider joining the group/practice is a NP or PA, the supervising physician's name is required.

Supervising Physician Name (if applicable) \_\_\_\_\_

Individual Provider NPI Number: \_\_\_\_\_ CAQH Provider Number: \_\_\_\_\_

**Note:** Please ensure the provider has completed and/or re-attested to the CAQH Application and has authorized Molina Healthcare to access the provider's record on the CAQH website.

MS Medicaid Provider ID: \_\_\_\_\_

Specialty: \_\_\_\_\_ Secondary Specialty: \_\_\_\_\_

Applying as: ☐ PCP ☐ Specialist ☐ Allied Health Professional

**Note:** A written collaborative agreement between a NP and a supervising physician is required if the NP is applying as a PCP. Please provide the collaborative agreement along with this form.

Board Certified: ☐ Yes ☐ No Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Certification Board: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_

Group/Practice Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

If you have any questions, visit our website at [MolinaHealthcare.com](https://www.molinahealthcare.com) or call Provider Services at (844) 826-4335. Representatives are available to assist you Monday through Friday from 7:30 a.m. to 6:00 p.m.

**Please mail, fax or email this form and supporting documentation to:**

Molina Healthcare of Mississippi  
Attn: Provider Network Administration  
1020 Highland Colony Parkway, Suite 602  
Ridgeland, MS 39157

[MHMSProviderContracting@MolinaHealthcare.com](mailto:MHMSProviderContracting@MolinaHealthcare.com)

[MolinaHealthcare.com](https://www.molinahealthcare.com)

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