Provider Information Update Form

This form is used to notify Molina Healthcare of Illinois of any changes to your practice information. This form may also be found online at **www.MolinaHealthcare.com**.

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:

☐ 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, please complete this form and include a W-9.*

Remittance Address	Physical Address
Address 1:	Address 1:
Address 2:	Address 2:
City, State, ZIP:	City, State, ZIP:

☐ TAX ID CHANGE

New Tax ID number:_____

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

Remittance Address	Physical Address
Address 1:	Address 1:
Address 2:	Address 2:
City, State, ZIP:	City, State, ZIP:

☐ 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: ____/____/_____	
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 JOINING GROUP

- *To add providers to your practice, please complete this form and include a Provider Roster for all new providers joining the group. The roster must be completed in full, including but not limited to: Accepting New Patients, Practice Capacity Maximum Enrollees, Practice As (PCP, SPEC, etc.) and Include Location in Directory.*

☐ PROVIDER NEEDS CREDENTIALED (Applicable only if registered on IMPACT)

- *To submit credentialing information please complete, CAQH Provider Data Form.*

☐ 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*

☐ SERVICE LOCATION - Additional Services

Please check off additional services offered at this location.

Service Location Name: _____

Physical Address 1: _____

Physical Address 2: _____

City, State, ZIP: _____

☐ 24 Hour Emergency Service	☐ Electronic Medical Records	☐ Kidney Transplant Programs	☐ Nursing Facility Supplies	☐ Parenteral & Enteral Nutrition	☐ Substance Abuse Residential Treatment
☐ Acute Rehabilitation	☐ Extended Office Hours	☐ Knee and Hip Replacement	☐ OB/GYN Services	☐ Pediatric Intensive Care Unit	☐ Surgical Services (Outpatient or ASC)
☐ Ambulatory Surgical Care Center	☐ Gynecological Services	☐ Lab Services	☐ Obstetrics Services	☐ Physical Therapy	☐ Telemedicine (Medical/BH)
☐ Behavioral Health (BH) Acute Care	☐ Heart Transplant Programs	☐ Level 3 Perinatal Facility	☐ Occupational Therapy	☐ Prosthetic/ Orthotic Supplier	☐ Urgent Care
☐ Behavioral Health (BH) Residential Treatment	☐ Home Health	☐ Liver Transplant Programs	☐ Orthotics and Prosthetics	☐ Radiology Services	☐ Virtual Visits
☐ Cancer Care	☐ Hospice	☐ Long-Term Acute Care (LTAC)	☐ Outpatient Dialysis	☐ Respiratory Therapy	☐ Weekend Hours
☐ Cardiac Care	☐ Immunization Provided	☐ Lung Transplant Programs	☐ Outpatient Infusion/ Chemotherapy	☐ Skilled Nursing Facilities	☐ 24 Hour Phone Coverage
☐ Dialysis Equipment & Supplies	☐ In Home Visits	☐ Mammography Services	☐ Oxygen Equipment	☐ Speech Therapy	
☐ Durable Medical Equipment	☐ Inpatient Psychiatric Services	☐ Neonatal Intensive Care Unit (NICU)	☐ Pancreas Transplant Programs	☐ Spine Surgery	

Name of individual completing this form (Please Print): _____

Phone Number: (____) _____ Fax Number: (____) _____

Email: _____ Date: ____/____/_____

If you have questions, contact the Provider Network Management team via email at **MHILProviderNetworkManagement@MolinaHealthcare.com**.

Please send the completed form to:
Molina Healthcare of Illinois
Fax: **(844) 488-7054** Email: **MHILProviderNetworkManagement@MolinaHealthcare.com**