Guide to provider forms

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	• PIF – Complete Section A and Section N* * Section N can be copied when adding multiple providers
Terming a provider	• PIF –Complete Section A and Section J • Term letter on your organization's letterhead
Closing a service location(s)	• PIF – Complete Section A and Section G • W-9 • Sample Claim Form (de-identified)
Change phone/fax	• PIF – Complete Section A and Section F
Change the pay-to/ billing address	• PIF – Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Change or add a service location	• PIF – Complete Section A and Section G
Add a new group to the same Tax Identification Number (TIN)	• PIF – Complete Section A • W-9 • Sample Claim Form (de-identified)
Change group name only	• PIF – Complete Section A and Section D • Sample Claim Form (de-identified) • W-9

Change TIN only	• PIF – Complete Section A and Section B • W-9 • Sample Claim Form (de-indentified)
Individual name change	• PIF – Complete Section A and Section E
Provider directory update	• PIF – Complete Section A and Section L
Panel update	• PIF – Complete Section A and Section K
Hospital affiliations update	• PIF – Complete Section A and Section M
Group/provider NPI change	• PIF – Complete Section A and Section C
Forms:	**Form usage:**
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare.
W-9	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 PIF.
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 www.caqh.org.
If you do not have a CAQH number	Go to www.caqh.org 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	Print, complete, fax, email or mail the Healthcare Delivery Organization Form. This form can be found on our website at MolinaHealthcare.com/Providers. Molina Healthcare of Nevada, Inc. Attention: Provider Network Administration 8329 W Sunset Road, Suite 100 Las Vegas, NV 89113 Email: NVProviderRelations@MolinaHealthcare.com
Contact information	If you have additional questions please contact Molina Healthcare's Provider Services department at (833) 685-2103 between the hours of 8 a.m. to 6 p.m. PT, Monday through Friday, or email NVProviderRelations@MolinaHealthcare.com.

Provider Information Update Form (PIF)

Today's date / /

This form and the associated documentation are required to notify Molina Healthcare of Nevada of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at MolinaHealthcare.com/NV.

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 (833) 685-2103. A representative will be available to assist you Monday through Friday, 8 a.m. to 6 p.m. PT.

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Section B

Tax ID number change Effective date / /

Previous tax ID number: _____ New tax ID number: _____

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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 #: _____

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Other changes

Section E

Individual name change

Previous name: _____ New name: _____

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Section F

Change phone/fax Effective date / /

Previous phone number: _____ New phone number: _____

Previous fax number: _____ New fax number: _____

Address: _____

City, state, ZIP: _____

Change applies to: Individual Provider NPI _____ Group NPI _____

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Section G

Effective date / /

☐ **Add a service location** ☐ **Change a service location** ☐ **Closure of a service location**

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: _____

Attach a list of providers at closed location with new service location assignments.

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: _____

Date: _____

Attach a list of rendering providers associated with the service location closure and the alternate service location to affiliate them with.

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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.

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Section J

Terming a provider

Provider name_____ Provider NPI_____

Reason for the term_____

Effective date of the term_____

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 terming provider is a PCP, who will assume patient panel?

Provider name (Last, first, MI)_____

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Section K

Panel update Effective date / /

Provider name_____ Provider NPI_____

☐ Existing patients only ☐ Close panel to all members ☐ Open panel

Reason: *(required)* _____

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Section L

Provider Directory update Effective date / /

Provider name_____ Provider NPI_____

☐ Include in Provider Directory ☐ Exclude from Provider Directory

Reason: *(required)* _____

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Section M

Hospital affiliations update Effective date / /

Provider name_____ Provider NPI_____

☐ Add hospital affiliation(s) ☐ Remove hospital affiliation(s)

Names of hospital(s): _____

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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 authorized Molina Healthcare to access CAQH.

MS Medicaid provider ID: _____

Specialty: _____ Secondary specialty: _____

Applying as: ■ PCP ■ Specialist ■ Allied Health Professional ■ Telehealth

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.

Primary Specialty Taxonomy _____ Secondary Specialty Taxonomy_____

License Number_____

License Effective date ___/___/_____ License Expiration date ___/___/_____

Lines of business for Provider to be added to: ■ Medicaid ■ Medicare ■ Marketplace

Medicare number_____ Provider gender_____

Languages Spoken_____

PCP: ■ Yes ■ No Minimum Age ___ Maximum Age ___

Board Certified: ■ Yes ■ No Effective date ___/___/_____ Expiration date ___/___/_____

Gender Restriction ■ M ■ F ■ Both Membership Capacity _____

Accepting new patients ■ Yes ■ No Telehealth ■ Yes ■ No

Provider performs EPSDT services ■ Yes ■ No Cultural training completed ■ Yes ■ No

Service location hours _____ Provider Directory Listing ■ Yes ■ No

Certification board: _____

Group/Practice name: _____

Group/Practice address: _____

City, state, ZIP: _____

Phone number: _____ Fax number: _____

Email: _____

Return to first page.

If you have any questions, visit our website at **MolinaHealthcare.com/NV** or call Provider Services at (833) 685-2103. Representatives are available to assist you Monday through Friday from 8 a.m. to 6 p.m. PT. Please mail, fax or email this form and supporting documentation to:

Molina Healthcare of Nevada
Attn: Provider Network Administration
8329 W Sunset Road, Suite 100
LasVegas, NV 89113
Fax: (833) 741-3182
NVProviderRelations@MolinaHealthcare.com