Provider Information Update Form

Use this form to notify Molina Healthcare of Wisconsin of any changes to your practice information. This form is also available at **MolinaHealthcare.com**.

CURRENT PRACTICE INFORMATION

Provider Last Name:	First Name:	Middle Initial:
Practice/Group Name:		
Group NPI Number:	Provider Medicaid Number:	
Provider NPI Number:	Provider Medicare Number:	
Current Provider/Practice Tax ID Number:		

Provide information on practice changes to be made:

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

Remittance Address	Physical Address
Address 1:	Address 1:
Address 2:	Address 2:
City, State, ZIP:	City, State, ZIP:
Effective Date: / /	

☐ TAX ID CHANGE

New Tax ID number:

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

Remittance Address	Physical Address
Address 1:	Address 1:
Address 2:	Address 2:
City, State, ZIP:	City, State, ZIP:
Effective Date: / /	

☐ ADDRESS CHANGE – SERVICE LOCATION

Service location(s) changed effective: / /	Check one: ☐ Current Location Update ☐ Additional/New Location

To change a service location or add an address in the Molina Healthcare 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:

☐ ADDRESS CHANGE – PAY-TO

Pay-To address changed effective: / /

To change your Pay-To address in our system, please complete this form and include a Form W-9.

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 Form W-9 is required to change the group practice name in the Molina system. Attach Form 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, complete this form and include a Provider Roster, in an Excel spreadsheet, for all new providers joining the group. The roster must be completed in full, including but not limited to: Accepting New Patients, Practice As (PCP, SPEC, etc.), Effective Date, and Provider (s) Location and List in Provider Directory.

MOLINA HEALTHCARE®

☐ **PROVIDER NEEDS CREDENTIALING**

To submit credentialing information, 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

☐ **ADDITIONAL COMMENTS**

List other demographic or provider data updates needed at this time.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of individual completing this form (Please Print):	
Phone Number:	Fax Number:
Date: / /	Email:

Email the completed form and all other materials to:
MHWIProviderNetworkManagement@MolinaHealthcare.com

MOLINA ®
HEALTHCARE