

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 <a href="#">Section A</a>, <a href="#">Section N*</a></li> <li>*<a href="#">Section N</a> can be copied when adding multiple providers</li> </ul>
Terminating a provider	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section J</a></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 <a href="#">Section A</a> and <a href="#">Section H</a></li> </ul>
Change Phone/Fax	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a>, <a href="#">Section F</a></li> </ul>
Change the Pay-To/ Billing Address	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section I</a></li> <li><a href="#">W-9</a></li> <li>Sample Claim Form (de-identified)</li> </ul>
Change or add a service location	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a>, <a href="#">Section G</a></li> </ul>
Add a new group to the same Tax Identification Number (TIN)	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a></li> <li><a href="#">W-9</a></li> <li>Sample Claim Form (de-identified)</li> </ul>
Change Group Name Only	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section D</a></li> <li>Sample Claim Form (de-identified)</li> <li><a href="#">W-9</a></li> </ul>
Change TIN only	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section B</a></li> <li><a href="#">W-9</a></li> <li>Sample Claim Form (de-identified)</li> </ul>

Individual Name Change	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section E</a></li> </ul>
Provider Directory Update	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section L</a></li> </ul>
Panel Update	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section K</a></li> </ul>
Hospital Affiliations Update	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section M</a></li> </ul>
Group/Provider NPI change	<ul style="list-style-type: none"> <li>PIF – Complete <a href="#">Section A</a> and <a href="#">Section C</a></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.
<a href="#">W-9</a>	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://www.caqh.org">http://www.caqh.org</a> .
If you do not have a CAQH number	Go to <a href="http://www.caqh.org">http://www.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 <a href="#">Healthcare Delivery Organization Form</a>.</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 Nevada, Inc. Attention: Provider Network Administration 8329 W Sunset Road, Suite 100 Las Vegas, NV 89113</p> <p>Email: <a href="mailto:NVProviderContracting@MolinaHealthCare.Com">NVProviderContracting@MolinaHealthCare.Com</a></p>
CONTACT INFORMATION	<p>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. PST, Monday through Friday.</p>

# 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 [www.MolinaHealthcare.com](http://www.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 (833) 685-2103. A representative will be available to assist you Monday through Friday, 8 a.m. - 6 p.m PST.

[Return to first page.](#)

## SECTION B

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

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

[Return to first page.](#)

## SECTION C

Group/Provider NPI Change

\_\_\_ Group \_\_\_ Individual

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

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

[Return to first page.](#)





## 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: \_\_\_/\_\_\_/\_\_\_

[Return to first page.](#)

## 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.

[Return to first page.](#)





## SECTION J

### Terminating a Provider

A termination letter is required on company letterhead including: name of the provider to be terminated, 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) \_\_\_\_\_

[Return to first page.](#)

## SECTION K

### Panel Update

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

Existing Patients Only

Close Panel to all Members

Open Panel

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

[Return to first page.](#)

## SECTION L

### Provider Directory Update

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

Include in Provider Directory

Exclude from Provider Directory

Reason: (Required)

[Return to first page.](#)

## SECTION M

### Hospital Affiliations Update

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

Add Hospital Affiliation(s)

Remove Hospital Affiliation(s)

Names of Hospital(s)

[Return to first page.](#)

## 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:

[Return to first page.](#)

If you have any questions, visit our website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) or call Provider Services at (833) 685-2103. Representatives are available to assist you Monday through Friday from 8 a.m. to 6:00 p.m PST.

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  
Las Vegas, NV 89113  
[NVProviderrelations@Molinahealthcare.com](mailto:NVProviderrelations@Molinahealthcare.com)

[MolinaHealthcare.com](http://MolinaHealthcare.com)