

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

OURRENT FRACTIOE IN ORMATION		
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	s/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 th		
To change your group name in our system, complete the Remittance Address	Physical Addre	ess
To change your group name in our system, complete the Remittance Address Address 1:	Physical Addre	ess
To change your group name in our system, complete the Remittance Address	Physical Addre	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP:	Physical Addre	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2:	Physical Addres Address 1: Address 2:	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP:	Physical Addres Address 1: Address 2:	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP:	Physical Addres Address 1: Address 2:	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP: Effective Date: / /	Physical Addres Address 1: Address 2:	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP: Effective Date: / /	Address 1: Address 2: City, State, ZIP:	ess
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP: Effective Date: / / TAX ID CHANGE New Tax ID number:	Address 1: Address 2: City, State, ZIP:	
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP: Effective Date: / / TAX ID CHANGE New Tax ID number: To change your Tax ID in our system, complete this for	Physical Addre Address 1: Address 2: City, State, ZIP: m and include a Form W-9.	
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP: Effective Date: / / TAX ID CHANGE New Tax ID number: To change your Tax ID in our system, complete this for Remittance Address	Physical Addre Address 1: Address 2: City, State, ZIP: m and include a Form W-9. Physical Addre	
To change your group name in our system, complete the Remittance Address Address 1: Address 2: City, State, ZIP: Effective Date: / / TAX ID CHANGE New Tax ID number: To change your Tax ID in our system, complete this form Remittance Address Address 1:	Physical Addre Address 1: Address 2: City, State, ZIP: m and include a Form W-9. Physical Addre Address 1:	

☐ 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 I required for all providers affected by this change.	Molina Healthcare system, a new Provider Roster is
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 o	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:
Pay-To Contact: Address 1:	Pay-To Contact: Address 1:
<i>,</i>	<i>,</i>
Address 1:	Address 1:
Address 1: Address 2:	Address 1: Address 2:
Address 1: Address 2: City, State, ZIP:	Address 1: Address 2: City, State, ZIP:
Address 1: Address 2: City, State, ZIP: Phone Number:	Address 1: Address 2: City, State, ZIP: Phone Number:
Address 1: Address 2: City, State, ZIP: Phone Number:	Address 1: Address 2: City, State, ZIP: Phone Number:
Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number: PRACTICE NAME CHANGE Practice name changed effective: / / • A copy of a Form W-9 is required to change the grouw-9 with this form. • To change the practice name in Molina Healthcare's	Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number:
Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number: PRACTICE NAME CHANGE Practice name changed effective: / / • A copy of a Form W-9 is required to change the ground W-9 with this form.	Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number:
Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number: PRACTICE NAME CHANGE Practice name changed effective: / / • A copy of a Form W-9 is required to change the ground W-9 with this form. • To change the practice name in Molina Healthcare's providers affected by this change.	Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number: Ip practice name in the Molina system. Attach Form system, a new Provider Roster is required for all
Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number: PRACTICE NAME CHANGE Practice name changed effective: / / • A copy of a Form W-9 is required to change the ground W-9 with this form. • To change the practice name in Molina Healthcare's providers affected by this change. New Practice Name	Address 1: Address 2: City, State, ZIP: Phone Number: Fax Number: Ip practice name in the Molina system. Attach Form system, a new Provider Roster is required for all Previous Practice Name

☐ 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.



PROVIDER NEEDS CREDENTIALING	
To submit credentialing information, complete, <u>CAQH Pro</u>	vider Data Form.
PROVIDER TERMING FROM GROUP - Note: No	tice required per termination language stated in contract.
Please complete this form and attach a letter on the com Name of provider to be termedGroup name	npany's letterhead including:
 Effective date of termination Reason for termination 	
Address(es) of practice location(s) affected by terminate	ation
☐ 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:

 $\underline{MHWIProviderNetworkManagement@MolinaHealthcare.com}$

