MICHIGAN PROVIDER CHANGE FORM

Please mail, fax or email this change form and supporting documents to:
Molina Healthcare of Michigan, 880 West Long Lake Road, Suite 600, Troy, MI 48098; Fax (248) 925-1757
Email MHMContractConfigDept@MolinaHealthCare.com
For Questions, please call the Provider Call Center at (855) 322-4077

Group Name:	Group NPI:	
Physician Name(s):	Individual NPI:	
Tax ID:	Today's Date:	Effective date of change:
Type of Provider: ☐ PCP ☐ SPC ☐ ANCILLARY ☐ HOSPITAL ☐ URGENT CARE ☐ FQHC/RHC/THC ☐ Dental/Dentist		
Authorized Submitter: (please print):	Title:	
Email Address: ☐ Please check here to receive health plan updates via email	Group Website:	
Type of Change: ☐ Demographic ☐ Office Hours ☐ Hospital Affiliation ☐ Include in Directory ☐ Exclude from Directory ☐ Specialty Update ☐ *Tax ID Change A change in ownership may require a new contract, please email our Provider Contracting Department at MHMProviderContractingMailbox@Molinahealthcare.com ☐ Voluntary Termination ☐ Involuntary Termination Reason: _____		
Panel Update: ☐ Open panel to all members (If you're requesting any other panel updates please contact your Provider Service Representative)		
Molina Product: ☐ Medicaid ☐ Medicare ☐ Marketplace ☐ MI Health Link (MMP)		
Comments/Other (please list any details regarding your request here):		

Provider Demographic Change Information

If the requested change affects multiple providers or service locations please include a separate roster with the additional information

Service Location Name	Current Information	Requested Change
☐ Check here if this is an additional location ☐ Check here if you are removing this location		
Address 1		
Address 2		
City, State Zip		
Contact Numbers	Phone:	Phone:
	Fax:	Fax:
*Pay to/Mailing	Current Information	Requested Change
Address 1		
Address 2		
City, State Zip		
Contact Numbers		
Tax ID		
PCMH Certification (submit certification)	Effective Date:	Term Date:
Internal Use Only: ☐ **Add a Network** _____ ☐ **Remove a Network** _____		

Membership Moves Reassignment for Terminated Providers

SUBJECT TO REVIEW BASED ON CONTRACT	From	To
Physician Name		
NPI		
Specialty		
Pay To Name		
Service Location Name		
Address		
Address 2 (if applicable)		
City, State Zip		

* Indicates that a W-9 form is required with submission (W-9 information must match your IRS documentation)