Provider Change Form
Requirements and Guidelines

Requirements

In order to process your change and to identify the requestor, the following fields are required to be complete:

1. Type 1 (Individual) NPI
2. Type 2 (Group) NPI
3. Provider Name
4. Group Name
5. Tax Identification Number (TIN)
6. Contact Person
7. Contact Person's phone number
8. Requested effective date of change
9. Authorizing signature and printed name

❖ If loading a group with more than one practice address please list the practice location name, address, phone and fax numbers on a roster.

Note: The Provider Change Form will be returned to you for completion, if submitted without these required elements.

The following types of changes require submission of the W-9 form (Tax form which certifies an individual's – TIN).

1. **Billing address change**
2. **TIN change- in addition to W-9 will need to submit IRS letter that matches the W-9**
3. **Group name change**
4. **Change of ownership**

Guidelines

1. Only one form per TIN. If submitting requests for multiple TINs, please submit multiple forms.
2. Requests will be applied to all participating lines of business.
3. Allow up to 30 days to complete the processing of your request.
4. Requests for a "Change of Ownership" require a new contract; the Molina contracting department will contact you.
5. Requests to "Change a physician name", require that you submit a copy of a marriage license, divorce decree, etc. as supporting documentation.
6. Requests to change a "TIN" require that you submit this form and W-9 as soon as the new TIN is available, to ensure timely and accurate processing of your claims.
   Note: A delay in notification may interrupt reimbursement.

Notification

Mail: Molina Healthcare of New Mexico
Attn: Network Services
400 Tijeras Ave NW, Suite 200
Albuquerque, NM 87102

E-Mail: MHNM.ProviderServices@Molinahealthcare.com
Fax: 505-798-7313

If you have any questions, please contact Molina Healthcare's Provider Contact Center at (844) 239-4914.

MOLINA HEALTHCARE

PROVIDER CHANGE FORM Today's Date:

NEW GROUP INFORMATION

ALL FIELDS IN FIRST SECTION ARE REQUIRED. Do not use this form if you're affiliated with a Delegated Group.

Type of Provider ☐ Ancillary ☐ Specialist ☐ Primary Care Provider ☐ Hospital Based Provider(Hospitalist) ☐ Clinic Based Provider ☐ Hospital ☐ Urgent Care ☐ FQHC/RHC ☐ LTSS ☐ Other

Provider Name:
Provider CAQH Number:
Registered with State Medicaid? ☐ **Yes** ☐ **No**
Provider NPI Number:
Phone #:
Fax #:
Gender: ☐ Male ☐ Female Date of Birth:
Who filled out this form (PRINT):
Primary Specialty:

Group Name:
Group Name Registered with State Medicaid? ☐ **Yes** ☐ **No**
Group NPI Number:
Tax ID:
Contact Person:
Email:
Requested Effective Date of Change:
Signature:

If more than one provider impacted by this change are you supplying a roster ☐ **Yes** ☐ **No** If Yes, please include all the following on said roster.

PROVIDER CHANGE/UPDATE/NEW INFORMATION

PROVIDE COMPLETE INFORMATION - Your request will be processed for all participating lines of business. ANYTHING marked with * will require you to submit a copy of your W-9 form with this change form. Please supply the changes you are requesting below . ** Only one request per TIN**

PLEASE PRINT OR TYPE

☐ Adding a Practice Address ☐ Deleting a Practice Address ☐ Billing Address Change* ☐ Telephone/Fax Change ☐ Office Hours Change
☐ Correct a Practice Address ☐ Include in Provider Directory ☐ Closed Panel (only established members) ☐ Open (accepting new members)

Street: City: State: Zip:

Phone: Fax: Office Hours:

Is the practice in compliance with the Americans with Disability Act and Handicapped Accessible? ☐ Yes ☐ No

If more than one location is impacted please provide additional addresses on a separate sheet.

☐ **TIN Change***

New Billing TIN: Effective Date of New Billing TIN:

Is this TIN change the result from a Change of Ownership? ☐ Yes ☐ No

Provide New Owner Legal Business Name & DBA if applicable:

Complete New Ownership & Disclosure Questions, if applicable – email NMPROVIDERCONTRACTING @molinahealthcare.com if form is needed.

☐ **Termination from Molina Healthcare Inc.**

Explanation/reason for termination:
If a PCP, who will be assuming your patient panel *(Last Name, First Name)*:

☐ **Add a** ☐ **Primary** ☐ **Secondary (*indicate one*) specialty** ☐ **Remove a** ☐ **Primary** ☐ **Secondary *(indicate one)* specialty**

Specialty Name: Taxonomy Code:

Provider Name Change Only*

Current Name: New Name:

☐ **Hospital Affiliation**

Hospital Name: Effective Date: ☐ Add ☐ Delete

☐ **Languages Spoken by Provider or Staff**

English Only ☐ **Other:**

* Indicates a W-9 Form is required with the submission along with the submitter's signature below

Signature

Printed name of person submitting

Please mail or email this change form and supporting documentation to:
Network Services
Molina Healthcare of New Mexico, 400 Tijeras Ave NW Suite 200 Albuquerque NM 87102
MHNM.ProviderServices @molinahealthcare.com