

Provider Demographic Update Form

Please read before completing this form:

- This form is for Molina Healthcare contracted providers only. To join the network, please visit our website at www.MolinaHealthcare.com.
- If you are a provider group and need to add a provider, please complete the provider information form. This can be found on our website at www.MolinaHealthcare.com.
- For large groups/facilities, please contact MCCAZ-Provider@molinahealthcare.com and request a roster template for your data changes*

Group/Agency Name:	Individual Practitioner Name:	Provider TIN:
Group/Agency NPI:	Practitioner NPI:	

Type of change

- Add

 Change

 Delete

Change category

- | | | |
|--|---|---|
| <input type="checkbox"/> Address Update/Change* | <input type="checkbox"/> Name Update/Change | <input type="checkbox"/> Phone # Update/Change |
| <input type="checkbox"/> Physical Address | <input type="checkbox"/> NPI Update/Change | <input type="checkbox"/> Medicare # Update/Change |
| <input type="checkbox"/> Payment Address | <input type="checkbox"/> TIN Update/Change | <input type="checkbox"/> Open or Close Panel (give detail below – e.g. no longer accepting members) |
| <input type="checkbox"/> Mailing Address | <input type="checkbox"/> Medicaid # Update/Change | |
| *For address changes/updates, please check all that apply | <input type="checkbox"/> Specialty Update/Change | |

Enter new/updated demographic information (only enter the information that you want us to update):

Name:	Address:	
City:	State:	ZIP code:
Phone #:	Fax #:	
NPI #:	TIN #:	
Medicaid #:	Medicare #:	
Specialty:		
Enter additional details about your change below:		

Please complete the below contact information so we can contact you if additional information is needed:

Contact Name and Title:
Contact Phone:
Contact Email:

Please email this completed form to MCCAZ-Provider@molinahealthcare.com or fax it to (888) 656-0369.