Date: _____ / ______ / ________

PROVIDER INFORMATION CHANGE FORM

Please fax or email this change form and supporting documentation to:
MHT Provider Services at (877) 900-8452 or MHTXProviderServices@MolinaHealthCare.Com

CURRENT PRACTICE INFORMATION

ALL FIELDS IN THIS SECTION ARE REQUIRED
Please Print or Type

Type of Provider: Ancillary ☐ Specialist ☐ Primary Care Provider ☐ LTSS ☐ Hospital ☐ Urgent Care ☐

Type 1 (Individual) NPI: ______________________________

Provider Name: ______________________________

Tax ID: ______________________________

Street: ______________________________

State: ______________ Zip: ________________

Contact Person: ______________________________

Authorizing Signature: ______________________________
(Physician/Office Manager Signature Required)

Type 2 (Group) NPI: ______________________________

Group Name: ______________________________

Phone #: (______)______________________________

City: ______________________________

Email: ______________________________

Fax #: ______________________________

Requested Effective Date of Change: ________________

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – Your request will be processed for all participating lines of business. Changes will be effective within 30 days. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 form with this change form. Please check the changes you are requesting.

PLEASE PRINT OR TYPE

Add a Practice Address ☐ Deleting a Practice Address ☐ Add to Provider Directory ☐ Remove from Provider Directory ☐

Address to be added or deleted:

Street: ______________________________ City: ________________ State: __________ Zip: __________
Phone: (______) ________________ Fax: (_______)________________ Office Hours:

Billing Address Change* ☐ Telephone/Fax Change ☐ Office Hours Change ☐ Correct Practice Address ☐
Include in Provider Directory ☐ Exclude from Provider Directory ☐

Updated Information:

Street: ______________________________ City: ________________ State: __________ Zip: __________
Phone: (______) ________________ Fax: (_______) ________________ Office Hours:

Tax ID Change* ☐

To update your Tax ID, please email MHTContractRequest@MolinaHealthcare.com.

Add Hospital Affiliation ☐ Delete Hospital Affiliation ☐

Hospital Name: ____

Panel Update ☐

Close Panel to all new members, but keep existing panel ☐ Open panel to all new members ☐
Close Panel to all members (new and existing) and reassign them to the follow physician: ______________________________
(Last name, First Name)

Reason (Required): ____

Add a Primary Specialty ☐ Add a Secondary Specialty ☐ Remove a Primary Specialty ☐ Remove a Secondary Specialty ☐

Specialty Name: ______________________ Taxonomy Code: ______________________

Name Change Only* ☐

Current Name: ______________________ New Name: ______________________

Change of Ownership* ☐

Legal Name of New Owner and Federal Tax ID: ______________________

Effective Date of Ownership: ______ /______ /______

Add a Covering Provider ☐ Remove a Covering Provider ☐

Provider Name:______________________ End Date of Coverage (if applicable): ______/______/______

ADDITIONAL I NFORMATION	SERVICES
Languages Spoken other than English: ______________________ ______________________ ______________________ ______________________ Indicate Office Hours, including evenings and weekends: ______ ______________________ ______________________ ______________________ Patient Age Range Accepted by Provider:______________________ ______________________	Please check off the below services that you offer: ☐ Pediatric Services ☐ Intellectual Disability Development ☐ Mental Health Rehabilitation Services ☐ Mental Health Targeted Case Management ☐ Telemedicine ☐ Telehealth ☐ Telemonitoring ☐ SE – Supported Employment ☐ EA – Employment Assistance ☐ Financial Management Services (CDS) ☐ Mobile Provider ☐ Public Transportation Accessible

Comments: ____

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*Indicates that a W-9 form is required with submission