



**MICHIGAN PROVIDER CHANGE FORM**

Please mail, fax or email this change form and supporting documents to:  
 Molina Healthcare of Michigan, 1201 Woodward Avenue, 9th Floor, Suite 900, Detroit, MI 48226;  
 Fax (248) 925-1757  
 Email [MHMContractConfigDept@MolinaHealthCare.com](mailto: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:	
<b>Type of Provider:</b> <input type="checkbox"/> PCP <input type="checkbox"/> SPC <input type="checkbox"/> ANCILLARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> URGENT CARE <input type="checkbox"/> FQHC/RHC/THC <input type="checkbox"/> Dental/Dentist			
Authorized Submitter: (please print):		Title:	
Email Address: <input type="checkbox"/> Please check here to receive health plan updates via email		Group Website:	
<b>Type of Change:</b> <input type="checkbox"/> Demographic <input type="checkbox"/> Office Hours <input type="checkbox"/> Hospital Affiliation <input type="checkbox"/> Include in Directory <input type="checkbox"/> Exclude from Directory <input type="checkbox"/> Specialty Update <input type="checkbox"/> *Tax ID Change A change in ownership may require a new contract, please email our Provider Contracting Department at <a href="mailto:MHMProviderContractingMailbox@Molinahealthcare.com">MHMProviderContractingMailbox@Molinahealthcare.com</a> <input type="checkbox"/> Voluntary Termination <input type="checkbox"/> Involuntary Termination Reason: _____			
<b>Panel Update:</b> <input type="checkbox"/> Open panel to all members (If you're requesting any other panel updates please contact your Provider Service Representative)			
<b>Molina Product:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Marketplace <input type="checkbox"/> 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
<input type="checkbox"/> Check here if this is an additional location <input type="checkbox"/> 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:
<b>Internal Use Only:</b> <input type="checkbox"/> Add a Network _____ <input type="checkbox"/> 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)