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: _____

Type 2 (Group) NPI: _____

Provider Name: _____

Group Name: _____

Tax ID: _____

Phone #: (_____) _____

Street: _____

City: _____

State: _____ Zip: _____

Email: _____

Contact Person: _____

Fax #: _____

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

Requested Effective Date of Change: _____

ATTENTION PROVIDERS:

All changes to demographic information for Medicaid-enrolled providers, including changes to service location information, must be made through the Provider Enrollment Management System (PEMS). Molina will receive these updates via the Master Provider File (MPF). Log in to your PEMS portal review your information and to make updates. Medicaid-enrolled providers can use the sections below (pages 1-2) to update information that is not required to be updated through PEMS.

If you are a provider who is not enrolled in Medicaid, but participates with Molina for other lines of business, please proceed to page [3] to complete your updates.

MEDICAID-ENROLLED PROVIDERS CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – 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 double-check the changes you are requesting.

PLEASE PRINT OR TYPE

Add address to Provider Directory ☐ Remove address from Provider Directory ☐

Deleting Practice Address (Please ensure address is also removed from PEMS profile if not already removed) ☐

Address to be added or removed:

Street: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____ Office Hours: _____

Billing Address Change* ☐ Telephone/Fax Change ☐ Office Hours Change ☐

Current Information:

Street: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____ Office Hours: _____

Updated Information:

Street: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____ Office Hours: _____

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: _____

Add a Covering Provider ☐ Remove a Covering Provider ☐

Provider Name: _____ End Date of Coverage (if applicable): ____ / ____ / ____

Tax ID Change* ☐

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

Name Change Only* ☐

Current Name: _____

New Name: _____

Change of Ownership* ☐

To submit a Change of Ownership update, please email MHTContractRequest@MolinaHealthcare.com

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

NON-MEDICAID-ENROLLED PROVIDERS CHANGE INFORMATION

Please note: Only providers who are not enrolled in Texas Medicaid should complete this section of the Change of Information form. If you are enrolled in Texas Medicaid, please review the sections on pages 1-2.

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:

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:

Add a Covering Provider ☐ Remove a Covering Provider ☐

Provider Name: _____ End Date of Coverage (if applicable): ____ / ____ / ____

Name Change Only* ☐

Current Name: _____ New Name: _____

Change of Ownership* ☐

To submit a Change of Ownership update, please email MHTContractRequest@MolinaHealthcare.com

Tax ID Change* ☐

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

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: _____

_____

_____

_____

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