# Guide to provider forms

| Action | You will need to complete the sections identified below on the Provider Information Update Form (PIF) and any additional documents listed. All documents must be completed and returned. |
|---|---|
| Add a Provider to the group | • PIF – Complete Section A and Section N*<br>* Section N can be copied when adding multiple providers |
| Terming a provider | • PIF –Complete Section A and Section J<br>• Term letter on your organization's letterhead |
| Closing a service location(s) | • PIF – Complete Section A and Section I<br>• W-9<br>• Sample Claim Form (de-identified) |
| Change phone/fax | • PIF – Complete Section A and Section F |
| Change the pay-to/ billing address | • PIF – Complete Section A and Section I<br>• W-9<br>• Sample Claim Form (de-identified) |
| Change or add a service location | • PIF – Complete Section A and Section G |
| Add a new group to the same Tax Identification Number (TIN) | • PIF – Complete Section A<br>• W-9<br>• Sample Claim Form (de-identified) |
| Change group name only | • PIF – Complete Section A and Section D<br>• Sample Claim Form (de-identified)<br>• W-9 |

| | |
|---|---|
| Change TIN only | • PIF – Complete Section A and Section B<br>• W-9<br>• Sample Claim Form (de-indentified) |
| Individual name change | • PIF – Complete Section A and Section E |
| Provider directory update | • PIF – Complete Section A and Section L |
| Panel update | • PIF – Complete Section A and Section K |
| Hospital affiliations update | • PIF – Complete Section A and Section M |
| Group/provider NPI change | • PIF – Complete Section A and Section C |
| **Forms:** | **Form usage:** |
| Provider Information Update Form (PIF) | This form is used to communicate changes, deletions and additions regarding participating providers to Molina Healthcare. |
| W-9 | This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name and Tax ID when received with a PIF. |
| **Credentialing — individual providers** | **You will need to:** |
| If you have a CAQH number | Complete CAQH Provider Data Form. You also need to update and give Molina Healthcare permission to review. Visit the website at www.caqh.org. |
| If you do not have a CAQH number | Go to www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review. |

| Credentialing — facilities and other providers | You will need to: |
|---|---|
| Including hospitals, ambulatory surgical centers, home health agencies, Durable Medical Equipment (DME) suppliers, SNFs, urgent care centers and retail clinics | Print, complete, fax, email or mail the Healthcare Delivery Organization Form. This form can be found on our website at MolinaHealthcare.com/Providers.<br><br>Molina Healthcare of Nevada, Inc.<br>Attention: Provider Network Administration<br>8329 W Sunset Road, Suite 100<br>Las Vegas, NV 89113<br><br>Email: NVProviderRelations@MolinaHealthcare.com |
| **Contact information** | If you have additional questions please contact Molina Healthcare's Provider Services department at (833) 685-2103 between the hours of 8 a.m. to 6 p.m. PT, Monday through Friday, or email NVProviderRelations@MolinaHealthcare.com. |

# Provider Information Update Form (PIF)

Today's date / /

This form and the associated documentation are required to notify Molina Healthcare of Nevada of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at MolinaHealthcare.com/NV.

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Type of group:

- ■ Medical group
- ■ Specialist
- ■ PCP
- ■ Hospital
- ■ Urgent care
- ■ FQHC/RHC
- ■ Behavioral Health
- ■ PHO-IPA
- ■ ASC
- ■ Other

## Section A

**Current group/Practice information** (*All fields in this section are required*)

Group/Practice name: _____

Group/Practice tax ID: _____ Group/Practice Medicaid #: _____

Group/Practice NPI #: _____ Contact number: _____

Email address: _____ Contact name: _____

**Group/Practice add, name change, tax ID number change and NPI change**
If changing both the Group/Practice name and the tax ID number, a new contract is required. Please contact Molina Healthcare Provider Services at (833) 685-2103. A representative will be available to assist you Monday through Friday, 8 a.m. to 6 p.m. PT.

*Return to first page.*

## Section B

**Tax ID number change** Effective date / /

Previous tax ID number: _____ New tax ID number: _____

*Return to first page.*

## Section C

**Group/Provider NPI change**

☐ **Group** ☐ **Individual**

Group/Provider name: _____

Previous NPI: _____

New NPI: _____

## Section D

**Group/Practice add or change** Effective date / /

Previous group/Practice name: _____ Medicaid #: _____

New group/Practice name: _____ Medicaid #: _____

*Return to first page.*

# Other changes

## Section E

**Individual name change**

Previous name: _____ New name: _____

*Return to first page.*

## Section F

**Change phone/fax** Effective date / /

Previous phone number: _____ New phone number: _____

Previous fax number: _____ New fax number: _____

Address: _____

City, state, ZIP: _____

*Return to first page.*

## Section G

☐ **Add a service location** Effective date / /

☐ **Change a service location**

**Previous address**

Address 1: _____

Address 2: _____

City, state, ZIP: _____

Phone number: _____

Fax number: _____

Email: _____

**New address**

Address 1: _____

Address 2: _____

City, state, ZIP: _____

Phone number: _____

Fax number: _____

Email: _____

*Return to first page.*

## Section H

**Closing a service location** Effective date / /

Address 1: _____

Address 2: _____

City, state, ZIP: _____

Reason: (required) _____

Authorizing signature printed: _____

Authorizing signature _____

Phone number: _____ Fax number: _____

Email: _____

Date: _____

*Return to first page.*

## Section I

**Billing address change** Effective date / /

| **Previous billing information** | **New billing information** |
|---|---|
| Billing contact: _____ | Billing contact: _____ |
| Address 1: _____ | Address 1: _____ |
| Address 2: _____ | Address 2: _____ |
| City, state, ZIP: _____ | City, state, ZIP: _____ |
| Phone number: _____ | Phone number: _____ |
| Fax number: _____ | Fax number: _____ |

Is this a Notice Address Change? ■ No ■ Yes

*The Notice Address is the particular party's address for delivery or mailing of notice purposes.*

*Return to first page.*

## Section J

**Terming a provider**

A termination letter is required on company letterhead including: name of the provider to be termed, group name, effective date of termination, reason for termination and address of practice location(s).
If terming provider is a PCP, who will assume patient panel?

Provider name (Last, first, MI)_____

*Return to first page.*

## Section K

**Panel update** Effective date / /

☐ Existing patients only ☐ Close panel to all members ☐ Open panel

Reason: *(required)* _____

*Return to first page.*

## Section L

**Provider Directory update** Effective date / /

☐ Include in Provider Directory ☐ Exclude from Provider Directory

Reason: *(required)* _____

*Return to first page.*

## Section M

**Hospital affiliations update** Effective date / /

☐ Add hospital affiliation(s) ☐ Remove hospital affiliation(s)

Names of hospital(s): _____

*Return to first page.*

## Section N

**Provider joining a Group/Practice** Effective Date ___/____/_____ Locum Tenen: ☐ Y ☐ N

Provider name (Last, first, MI):_____

Provider type (MD, DO, DDS, NP, PA, etc): ____ Date of birth: _____

*Note: If the provider joining the group/practice is a NP or PA, the supervising physician's name is required.*

Supervising physician name (if applicable): _____

Individual provider NPI number: _____ CAQH provider number: _____

*Note: Please ensure the provider has completed and/or re-attested to the CAQH application and authorized Molina Healthcare to access CAQH.*

MS Medicaid provider ID: _____

Specialty: _____ Secondary specialty: _____

Applying as: ☐ PCP ☐ Specialist ☐ Allied Health Professional ☐ Telehealth

*Note: A written collaborative agreement between a NP and a supervising physician is required if the NP is applying as a PCP. Please provide the collaborative agreement along with this form.*

Board Certified: ☐ Yes ☐ No Effective date ___/___/_____ Expiration date ___/___/_____

Certification board: _____

Group/Practice name: _____

Group/Practice address: _____

City, state, ZIP: _____

Phone number: _____ Fax number: _____

Email: _____

*Return to first page.*

If you have any questions, visit our website at **MolinaHealthcare.com/NV** or call Provider Services at (833) 685-2103. Representatives are available to assist you Monday through Friday from 8 a.m. to 6 p.m. PT. Please mail, fax or email this form and supporting documentation to:

Molina Healthcare of Nevada
Attn: Provider Network Administration
8329 W Sunset Road, Suite 100
LasVegas, NV 89113
Fax: (833) 741-3182
NVProviderRelations@MolinaHealthcare.com