Provider Change Form
Requirements and Guidelines

REQUIREMENTS

In order to process your change and to identify the requestor, the following fields are required to be complete:

1. Type 1 (Individual) NPI
2. Type 2 (Group) NPI
3. Provider Name
4. Group Name
5. Tax Identification Number (TIN)
6. Contact Person
7. Contact Person's phone number
8. Requested effective date of change
9. Authorizing signature and printed name

❖ If loading a group and service location or more than one service location please list the service location name, address, phone and fax numbers on a roster.

Note: The Provider Change Form will be returned to you for completion, if submitted without these required elements, or if the provider and group are not registered with the State of Utah Medicaid Agency.

The following types of changes require submission of the W-9 form (Tax form which certifies an individual's tax identification number – TIN).

1. Billing address change
2. Tax ID change
3. Group name change
4. Change of ownership

GUIDELINES

2. Only 1 form per Tax ID. If submitting requests for multiple TIN's, please submit multiple forms.
3. Requests will be applied to all participating lines of business.
4. Allow up to 30 days to complete the processing of your request.
5. Requests for a *"Change of Ownership"* require a new contract; the Molina contracting department will contact you.
6. Requests to *"Change a physician name"*, require that you submit a copy of a marriage license, divorce decree, etc… as supporting documentation.
7. Requests to change a *"Tax ID"* require that you submit your request and W-9 as soon as the new tax identification number is available, to ensure timely and accurate processing of your claims. ***Note: A delay in notification may interrupt claims reimbursement.***

NOTIFICATION

Mail: Molina Healthcare of Utah
Attn: Provider Network Administration
7050 Union Park Center
Suite 200
Salt Lake City, UT 84047

E-Mail: MHUPIM@MolinaHealthCare.Com
Fax: 1-855-849-1103

If you have any questions, please contact Molina Healthcare's Provider Contact Center at 1-888-483-0760

MOLINA HEALTHCARE

PROVIDER CHANGE FORM Today's Date: _____

NEW GROUP INFORMATION

ALL FIELDS IN FIRST SECTION ARE REQUIRED. Do not use this form if you're affiliated with a Delegated Group.

Type of Provider ☐ Ancillary ☐ Specialist ☐ Primary Care Provider ☐ Hospital Based Provider(Hospitalist) ☐ Clinic Based Provider ☐ Hospital ☐ Urgent Care ☐ FQHC/RHC ☐ LTSS ☐ Other

Provider Name: _____
Provider CAQH Number: _____
Registered with State Medicaid? ☐ **Yes** ☐ **No**
Provider NPI Number: _____
Phone # (____) _____
Fax # (____) _____
Gender: ☐ Male ☐ Female Date of Birth: _____
Who filled out this form (PRINT): _____
Primary Speciality _____

Group Name: _____
Group Name Registered with State Medicaid? ☐ **Yes** ☐ **No**
Group NPI Number: _____
Tax ID: _____
Contact Person: _____
Email: _____
Requested Effective Date of Change: _____
Signature: _____

If more than one provider impacted by this change are you supplying a roster ☐ **Yes** ☐ **No** If Yes, please include all the following on said roster.

PROVIDER CHANGE/UPDATE/NEW INFORMATION

PROVIDE COMPLETE INFORMATION - Your request will be processed for all participating lines of business. ANYTHING marked with * will require you to submit a copy of your W-9 form with this change form. Please supply the changes you are requesting below. ***Only 1 request per tax ID***

PLEASE PRINT OR TYPE

☐ Adding a Practice Address ☐ Deleting a Practice Address ☐ Billing Address Change* ☐ Telephone/Fax Change ☐ Office Hours Change
☐ Correct a Practice Address ☐ Include in Provider Directory ☐ Closed Panel (only established members) ☐ Open (accepting new members)

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

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

Is Location in Compliance with Americans with Disability Act and Handicapped Accessible? ☐ Yes ☐ No

If more than one location is impacted please provide additional addresses on a separate sheet.

☐ **Tax ID Change***

New Billing Tax ID: _____ Effective Date of New Billing Tax ID: ____/____/_____

Is this Tax ID change the result from a Change of Ownership? ☐ Yes ☐ No

Provide New Owner Legal Business Name & DBA if applicable: _____

Complete New Ownership & Disclosure Questions if applicable – email MHUPIM@molinahealthcare.com for a copy if you need one.

☐ **Termination from Molina Healthcare Inc.**

Explanation/reason for termination: _____
If a PCP, who will be assuming your patient panel *(Last Name, First Name)* : _____

☐ **Add a** ☐ **Primary/** ☐ **Secondary (*indicate one*) specialty** ☐ **Remove a** ☐ **Primary /** ☐ **Secondary *(indicate one)* specialty**

Specialty Name: _____ Taxonomy Code: _____

Provider Name Change Only*

Current Name: _____ New Name: _____

☐ **Hospital Affiliation**

Hospital Name: _____ Effective Date: _____ ☐ Add ☐ Delete

☐ **Languages Spoken by Provider or Staff**

English Only ☐ **Other:** _____

Please mail or email this change form *and* supporting documentation to:
Provider Network Administration, Molina Healthcare of Utah, 7050 Union Park Center Suite 200 Midvale UT 84047
MHUPIM@MolinaHealthCare.Com

For Questions, please call the Provider Call Center at 888-483-0760

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

Revised 9/5/18