

This form is used to notify Molina Healthcare of Wisconsin of any changes to your practice information.

CURRENT PRACTICE INFORMATION

Provider Last Name: _____	First Name: _____	Middle Initial: _____
Practice/Group Name: _____		
Group Medicaid Number: _____	Provider Medicaid Number: _____	
Provider NPI Number: _____	Provider Medicare Number: _____	
Current Provider/Practice Tax ID Number: _____		

Please provide the information on the changes to be made to the practice information:

PCP/Panel/Directory Flag Update

<input type="checkbox"/> PCP	<input type="checkbox"/> Accepting New Members	<input type="checkbox"/> Include in Provider Directory
Service locations affected by this change: _____		
<ul style="list-style-type: none">• If multiple service locations affected please attach list of service locations.		

Individual Name CHANGE

New Last Name: _____	New First Name: _____	Middle Initial: _____
<ul style="list-style-type: none">• An updated Provider Roster is required for all practices/groups affected by this change.		

ADDING NEW GROUP TO SAME TIN

New Group Name: _____
<ul style="list-style-type: none">• To change your group name in our system, please complete this form and include a W-9.

TAX ID CHANGE

New Tax ID number: _____
<ul style="list-style-type: none">• To change your Tax ID in our system, please complete this form and include a W-9.

ADDRESS CHANGE

Service location(s) changed effective: ____/____/____ Check one: New Location Additional Location

- To change a service location or add an address in Molina Healthcare's system, a new Provider Roster is required for all providers affected by this change.

New Address/Phone Number	Previous Address/Phone Number
Address 1:	Address 1:
Address 2:	Address 2:
City, State Zip:	City, State Zip:
Phone Number: ()	Phone Number: ()
Fax Number: ()	Fax Number: ()

PAY TO ADDRESS CHANGE

Pay To address changed effective: ____/____/____ - an updated W-9 is also required to update your pay to address.

New Pay To Address/Phone Number	Previous Pay To Address/Phone Number
Pay To Contact:	Pay To Contact:
Address 1:	Address 1:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
Phone Number: ()	Phone Number: ()
Fax Number: ()	Fax Number: ()

PRACTICE NAME CHANGE

Practice name changed effective: ____/____/____

- A copy of a **W-9** is required to change the group practice name in Molina's system. Please attach the W-9 with this form.
- To change the practice name in Molina Healthcare's system, a new Provider Roster is required for all providers affected by this change.

New Practice Name	Previous Practice Name
New Practice Name:	Previous Practice Name:
Medicaid Number:	Medicaid Number:

PROVIDER TERMING FROM GROUP - Note: Notice required per termination language stated in contract.

Please complete this form and attach a letter on the company's letterhead including:

- Name of provider to be termed • Group name • Effective date of termination
- Reason for termination • Address(es) of practice location(s) effected by termination

Name of individual completing this form (Please Print): _____

Phone Number: () _____ Fax Number: () _____

Email: _____ Date: ____/____/____

If you have any questions or concerns, please visit our website at www.MolinaHealthcare.com, or call the Provider Services Department at ((855) 326-5059. A representative will be available to assist you from 8 a.m. - 5p.m., Monday through Friday.

Please send the completed form to:

Fax: (877) 556-5863 Email: mhwiprvider.services@molinahealthcare.com