MOLINA HEALTHCARE

PROVIDER CHANGE FORM

Today's Date: _____/_____/_____

CURRENT PRACTICE INFORMATION
ALL FIELDS IN THIS SECTION ARE REQUIRED

Type of Provider: ☐ Ancillary ☐ Specialist ☐ Primary Care Provider ☐ Hospital ☐ Urgent Care

Type 1 (Individual) NPI: ☐☐☐☐☐☐☐☐☐☐ Type 2 (Group) NPI: ☐☐☐☐☐☐☐☐☐☐

Provider Name: _____ Group Name: _____

Tax ID: ☐☐ - ☐☐☐☐☐☐☐

Contact Person: _____ Phone #: (_____) _____

Requested Effective date of change: _____

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION - Your request will be processed for all participating lines of business. Changes will be effective within 60 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

Adding a Practice Address | Deleting a Practice Address | Billing Address Change* | Telephone/Fax Change
Office Hours Change | Include in Provider Directory | Exclude from Provider Directory
Correct a Practice Address

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

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

Tax ID Change *

New Tax ID: ☐☐ - ☐☐☐☐☐☐☐

☐ **Add Hospital Affiliation** ☐ **Delete Hospital Affiliation**

Hospital Name: _____

Panel Update

☐ Close panel to all new members, but keep existing panel ☐ Open panel to all members

☐ Close panel to all members (new and existing) and reassign them to the following physician:

_____

(*Last Name, First Name*)

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

Specialty Name: _____ Taxonomy Code: _____

Name Change Only *

Current Name: _____ New Name: _____

Change of Ownership *
_____ Effective date of ownership: _____/_____/_____ *Legal Business Name of New Owner and Federal Tax ID*
☐ **Add a Covering Provider** ☐ **Remove a Covering Provider**
Provider Name: _____ Effective date of ownership: _____/_____/_____

Please email or mail this change form and supporting documentation to:

Contracting, Molina Healthcare of South Carolina, PO Box 40309 North Charleston, SC 29423-0309.

SCNetworkAdministration@MolinaHealthcare.com

For Questions, please call the Provider Call Center at (855) 237-6178.

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