Termination Notification Form

Individual Provider Termination Notification Form

Please complete this form and return via email: MHWPS.ProviderTerminations@MolinaHealthcare.com

Notification Requirements

This form should be submitted 60 days in advance of a provider's last day. Please submit as soon as possible if you are providing less than 60 days' notice as Molina may be required to provide timely member notifications. This form MUST be completed in its entirety to be processed.

Provider Information

Provider Type: ☐ Primary Care Provider ☐ Specialist

Provider Last Name: _____

Provider First Name: _____

Individual NPI: _____

Group Information

Payto/Group Name: _____

Tax ID Number (TIN): ☐☐-☐☐☐☐☐☐☐

Service Location Name: _____

Service Location Address: _____

Group Contact Name: _____

Group Contact Phone: _____

Group Contact Email: _____

Termination Details

Date of Termination: _____

Type of Termination: ☐ Complete Termination from Group ☐ Terminate Specific Service Location

Termination Reason: ☐ Retired ☐ Relocated ☐ Deceased ☐ Left Group
☐ License Restriction/Sanction ☐ Other: _____

Additional Information/Comments/Special Instructions: