

Guide to Provider Forms

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ATTACH ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED.
Add a Provider to the group	<ul style="list-style-type: none"> PIF – Complete Section A, Section N* *Section N can be copied when adding multiple providers
Terminating a provider	<ul style="list-style-type: none"> PIF – Complete Section A and Section J Term letter on your organization’s letterhead
Closing a service location(s)	<ul style="list-style-type: none"> PIF – Complete Section A and Section H
Change Phone/Fax	<ul style="list-style-type: none"> PIF – Complete Section A, Section F
Change the Pay-To/ Billing Address	<ul style="list-style-type: none"> PIF – Complete Section A and Section I W-9 Sample Claim Form (de-identified)
Change or add a service location	<ul style="list-style-type: none"> PIF – Complete Section A, Section G
Add a new group to the same Tax Identification Number (TIN)	<ul style="list-style-type: none"> PIF – Complete Section A W-9 Sample Claim Form (de-identified)
Change Group Name Only	<ul style="list-style-type: none"> PIF – Complete Section A and Section D Sample Claim Form (de-identified) W-9
Change TIN only	<ul style="list-style-type: none"> PIF – Complete Section A and Section B W-9 Sample Claim Form (de-identified)

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Individual Name Change	<ul style="list-style-type: none"> PIF – Complete Section A and Section E
Provider Directory Update	<ul style="list-style-type: none"> PIF – Complete Section A and Section L
Panel Update	<ul style="list-style-type: none"> PIF – Complete Section A and Section K
Hospital Affiliations Update	<ul style="list-style-type: none"> PIF – Complete Section A and Section M
Group/Provider NPI change	<ul style="list-style-type: none"> 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 http://www.caqh.org .
If you do not have a CAQH number	Go to http://www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review.

<p>Credentialing - Facilities and Other Providers</p>	<p>YOU WILL NEED TO ...</p>
<p>Including Outpatient Hospitals, & Ambulatory Surgical Centers,</p>	<p>Print, complete, fax, email or mail the Facility/HealthCare Delivery Organization (HDO)/Long Term Special Services (LTSS) Credentialing Application.</p> <p>Also, please include the Disclosure of Ownership and Control Form and a W9.</p> <p>These forms can be found on our website at www.passporthealthplan.com</p> <p>Passport Health Plan by Molina Healthcare Attention: Provider Contracts 2028 W. Broadway Louisville, KY 40203 Fax#: (833) 529-1081</p> <p>Email: contracting@passporthealthplan.com</p>
<p>CONTACT INFORMATION</p>	<p>If you have additional questions please contact Molina Healthcare’s Provider Services department at (844) 862- 4564 between the hours of 8:00 a.m. to p.m. CST, Monday through Friday.</p>

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Provider Information Update Form (PIF)

Today's Date ____ / ____ / ____

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

Type of Group: General Dentist Specialist RDH

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 Dental Services at (844) 826-4335. A representative will be available to assist you Monday through Friday, 8 a.m. - 5 p.m EST.

[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: _____

[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 Address: _____

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

Terminating a Provider

A termination letter is required on company letterhead including: name of the provider to be terminated, group name, effective date of termination, reason for termination and address of practice location(s).

If terminating provider is a PCD, 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 (DDS, DMD, RDH, etc.): _____ Date of Birth: _____

Note: Please ensure the provider has completed and/or re-attested to the CAQH Application and has authorized Molina Healthcare to access the provider’s record on the CAQH website.

Medicaid Provider ID:

Specialty: _____ Secondary Specialty: _____

Board Certified: __Yes__ __No__ Effective Date: ____/____/____ Expiration Date: ____/____/____

Certification Board: _____

Group/Practice Name: _____

Group/Practice Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

[Return to first page.](#)

If you have any questions, visit our website at www.MolinaHealthcare.com or call MDS Provider Services at (844) 862-4564. Representatives are available to assist you Monday through Friday from 8:00 a.m. to 5:00 p.m. CST.

Please fax or email this form and supporting documentation to:

Passport by Molina Healthcare
Attn: MDS Provider Services
Fax: (855) 297-3304
mdvsproviderservices@molinahealthcare.com