ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED
Add a Provider to the group	• PIF — Complete Section A, Section N* *Section N can be copied when adding multiple providers
Terming a provider	• PIF — Complete Section A and Section J • Term letter on your organization's letterhead
Closing a service location(s)	• PIF — Complete Section A and Section H
Change Phone/Fax	• PIF — Complete Section A, Section F
Change the Pay-To/ Billing Address	• PIF — Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Change or add a service location	• PIF — Complete Section A, Section G
Add a new group to the same Tax Identification Number (TIN)	• PIF — Complete Section A • W-9 • Sample Claim Form (de-identified)
Change Group Name Only	• PIF — Complete Section A and Section D • Sample Claim Form (de-identified) • W-9
Change TIN only	• PIF — Complete Section A and Section B • W-9 • Sample Claim Form (de-identified)

Individual Name Change	• PIF — Complete Section A and Section E
Provider Directory Update	• PIF — Complete Section A and Section L
Panel Update	• PIF — Complete Section A and Section K
Hospital Affiliations Update	• PIF — Complete Section A and Section M
Group/Provider NPI change	• 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 your CAQH application. 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.

Credentialing – Facilities and Other Providers	YOU WILL NEED TO …
CONTACT INFORMATION	If you have additional questions, please contact Molina Dental Services at (844) 862-4564 8 a.m. to 5 p.m. CST, Monday through Friday.
MEDICAID ID #	Prior to credentialing a provider must acquire a valid Medicaid ID number for each location they plan on practicing at. Additionally, the location itself must have a valid Medicaid ID number. These can be obtained through Maximus by either phone or email. • (844)-374-5022 • nebraskamedicaidPSE@maximus.com

Provider Information Form (PIF)

Today's Date ___/___/_____

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

Nebraska Medicaid requires all participating providers have:

- **A rendering Medicaid ID**
- **A group Medicaid ID**
- **A location Medicaid ID**

Type of Group: ☐ Medical Group ☐ Specialist ☐ PCD ☐ Hospital ☐ Urgent Care

☐ FQHC/RHC ☐ Behavioral Health ☐ PHO-IPA ☐ ASC ☐ DDS

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) 862-4564 8 a.m. to 5 p.m. CST, Monday through Friday.

SECTION B

Tax ID Number Change _____ Effective Date _____

Previous Tax ID Number _____ New Tax ID Number_____

SECTION C

Group/Provider NPI Change

____ Group ____ Individual

Group/Provider Name: _____

Previous NPI: New NPI: _____

SECTION D

Group/Practice Add or Change _____ Effective Date _____/_____/ _____

Previous Group/Practice name: _____ Medicaid #: _____

New Group/Practice name: _____ Medicaid #: _____

OTHER CHANGES

SECTION E

Individual Name Change

Previous Name: _____ New Name: _____

SECTION F

Change Phone/Fax _____ Effective Date ___/___/_____

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

SECTION G

☐ Add a Service Location ☐ Change a Service Location Effective Date: ___/___/_____

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: ___/___/_____

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.

SECTION J

Terming a Provider

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

If terming provider is a PCD, who will assume patient panel?

Provider Name (Last, First, MI) _____

SECTION K

Panel Update Effective Date____/____/_____

☐ Existing Patients Only ☐ Close Panel to all Members ☐ Open Panel

Reason: (Required) _____

SECTION L

Provider Directory Update Effective Date ____/_____/ _____

☐ Include in Provider Directory ☐ Exclude from Provider Directory

Reason: (*Required*)_____

SECTION M

Hospital Affiliations Update Effective Date_____/_____/ _____

☐ Add Hospital Affiliation(s) ☐ Remove Hospital Affiliation(s)

☐ Names of Hospital(s) _____

SECTION N

Provider Joining a Group/Practice Effective Date: ____/___/_____ Locum Tenon: ☐ Y ☐ N

Provider Name (Last, First, MI):_____ _____

Provider Type (MD, DO, DDS, NP, PA, etc.): _____ Date of Birth:_____

Note: If the provider joining the group/practice is a NP or PA, the supervising physician's name is required.

Supervising Physician Name (if applicable) _____

Individual Provider NPI Number: _____ CAQH Provider Number: _____

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.

NE Medicaid Provider ID:_____

Specialty: _____ Secondary Specialty: _____

Applying as: ☐ PCD ☐ Specialist ☐ Allied Health Professional

Note: A written collaborative agreement between a NP and a supervising physician is required if the NP is applying as a PCP. Please provide the collaborative agreement along with this form.

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:_____

If you have any questions, visit our website at www.MolinaHealthcare.com or call Molina Dental Services at (844) 862-4564 8 a.m. to 5 p.m. CST, Monday through Friday.

Please fax or email this form and supporting documentation to:

Molina Healthcare of Nebraska
Attn: MDS Provider Services
Fax: (855) 297-3304
mdvsproviderservices@MolinaHealthCare.Com