

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)

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.

MolinaHealthcare.com



Provider Information Update Form (PIF)

Today's Date ____ / ____ / ____

This form and the associated documentation are required to notify Molina Healthcare of Illinois 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) 862-4564. A representative will be available to assist you Monday through Friday, 8 a.m. - 5 p.m EST.

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SECTION B

Tax ID Number Change _____ Effective Date ____ / ____ / ____

Previous Tax ID Number _____ New Tax ID Number _____

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SECTION C

Group/Provider NPI Change

____ Group ____ Individual

Group/Provider Name: _____

Previous NPI: _____ New NPI: _____

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SECTION D

Group/Practice Add or Change

Effective Date ____/____/____

Previous Group/Practice name: _____ Medicaid #: _____

New Group/Practice name: _____ Medicaid #: _____

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OTHER CHANGES

SECTION E

Individual Name Change

Previous Name: _____ New Name: _____

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SECTION F

Change Phone/Fax

Effective Date ____/____/____

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

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SECTION G

Add a Service Location Change a Service Location Effective Date: ____/____/____

Previous Address New Address

Address 1: _____ Address 1: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Phone Number: _____

Fax Number: _____ Fax Number: _____

Email: _____ Email: _____

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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: ___/___/___

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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.

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SECTION J

Terminating 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 terminating provider is a PCD, who will assume patient panel?

Provider Name (Last, First, MI) _____

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SECTION K

Panel Update

Effective Date ____/____/____

Existing Patients Only

Close Panel to all Members

Open Panel

Reason: (Required) _____

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SECTION L

Provider Directory Update

Effective Date ____/____/____

Include in Provider Directory

Exclude from Provider Directory

Reason: (Required)

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SECTION M

Hospital Affiliations Update

Effective Date ____/____/____

Add Hospital Affiliation(s)

Remove Hospital Affiliation(s)

Names of Hospital(s)

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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.

IL 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: _____

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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 6:00 p.m. CT.

Please email this form and supporting documentation to:

Molina Dental Services at:

FAX: (855)297-3304

EMAIL:

MDVSpviderservices@molinahealthcare.com