MOLINA HEALTHCARE
Your Extended Family.

Healthy Connections PRIME

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

Please email, fax or mail this change form and supporting documentation to: fax (843) 740-1783
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.