Who Uses This Packet

You should use this packet when:

Updating rendering provider general information.

General Instructions

The following information is important. If you have questions, contact Molina Provider Enrollment at 1 (866) 686-4272 or e-mail idproviderenrollment@molinahealthcare.com.

- All information is required. Be sure to fill out all fields. If there is a field that does not pertain, please enter "NA."
- Any required addenda or supporting documentation (such as a copy of a certification) must be submitted with the packet.
- Incomplete packets, including packets that are missing the required addenda or supporting documentation, will result in an e-mail from Provider enrollment asking for the missing information.
- The effective date of an applicant's affiliation to an existing provider agreement is deemed to be the date the application has been fully reviewed and approved by IDHW and Molina Provider Enrollment.
- Providers are required to report any changes to their Idaho Medicaid provider file within 30 days of the date of the change (per section 2.2 of the Idaho Medicaid Provider Agreement and section 2.1.3 of the Provider Handbook – General Provider and Participant Information).
- All packet documents are interactive PDF files, allowing users to enter information into the fields directly from the computer screen. This information can then be saved to a file and printed for mailing. Using these interactive features facilitates both the packet's completion and review processes.

Next Steps

1) Print the completed packet.
2) Make a copy of the packet for your records.
3) Mail, fax, or e-mail the packet, including all required addenda and supporting documentation, to the following address:

   Molina Medicaid Solutions
   PO Box 70082
   Boise, ID 83707
   Fax: 1 (877) 517-2041
   E-mail: idproviderenrollment@molinahealthcare.com

Current Provider and Contact Information

Current Pay-To Provider Information	
Pay-To Name of Group, Organization, or Individual:	
National Provider Identifier (NPI):	Tax ID (FEIN or SSN):
Contact Information	
The contact name and e-mail relate to the person who can answer questions about the information provided in this packet. E-mail addresses are used for IDHW business only and will not be sold or shared for other purposes.	
Contact Name (first name, last name):	Phone (with area code):
Contact E-mail Address:	
Billing Contact Name:	Billing Contact Phone (with area code):

Pay-To NPI or Idaho Medicaid # _____

Changes to Rendering Provider General Information

Complete the sections in the table below where the general information for the rendering provider has **changed**; if the information in a section has not changed, leave it blank. For example, if the physical address has changed, but the mailing address has not, complete the physical address sections and the mailing address sections blank.

Rendering Provider General Information		
Effective Date for Change:	Provider NPI:	
First and Last Name:		
Date of Birth:	Social Security Number:	
Physical Address 1:		
Physical Address 2:		
City:	State or Province:	Zip / Postal Code:
E-mail Address:		
Phone:	Fax:	Emergency Phone:
Mailing Address 1:		
Mailing Address 2:		
City:	State or Province:	Zip / Postal Code:

Pay-To NPI or Idaho Medicaid # _____

Provider Statement

I certify that I am the provider, or I am authorized on behalf of the provider to sign this documentation. I certify this is true, correct, and complete. If I become aware that any information in this document is not true, correct, and complete, I will notify Molina Provider Enrollment of this fact immediately. I authorize the Medicaid provider enrollment unit to verify the information contained herein. I understand that a change in the ownership of my organization or my status as an individual or group biller may require a new application.
Provider Name (print):
Provider Authorized Signature:
Title:
Date: