Provider Termination Form

Please complete this form and return via email to: MHTXProviderTermRequests@MolinaHealthcare.com.

Notification Requirements

This form must be submitted at least ninety (90) days prior to the provider's requested termination date. If you are providing less than 90 days' notice, please submit the form as soon as possible to ensure timely member notifications can be sent by Molina. The form must be fully completed to be processed.

Termination Type: ☐ Provider Term ☐ Group Term ☐ Delegated Provider _____

Provider Information

Provider Type: ☐ Primary Care Provider ☐ Specialist ☐ Home Health ☐ LTSS ☐ DME ☐ Facility/Hospital

Provider Last Name: _____

Provider First Name: _____

Individual NPI: _____

Group Information

Practice/Group Name: _____

Tax ID Number (TIN): _____

Group NPI: _____

Service Location Address: _____

Termination Details

Date of Termination: _____

Termination Reason (check appropriate reason):

☐ Provider Moved ☐ Provider Retired ☐ Provider Left Group ☐ Provider Closed Practice

☐ Provider Deceased ☐ License Restriction/Sanction ☐ Program Integrity Issue

☐ Other (explain) _____

Name of Requestor (Please Print): _____

Group Contact Phone: _____

Group Contact Email: _____

Additional Information/Comments/Special Instructions: _____

_____

Provider Relations Representative Initials: ____

Date: _____