For Molina Medicaid Solutions Internal Use Only					
Provider Name:				Provider ID #:	
Doc Type:	**CHNGREQ**	Provider Type:		Provider Specialty:	

SIGNATURE AUTHORIZATION FORM

Date:

Dear Provider:

If anyone other than the practitioner is authorized to sign and certify Medicaid claims and supporting documents, the signature of that person must appear on the claim form as indicated below (**NOT THE PRACTITIONER'S NAME**). If the authorized individual is the Medicaid Provider, he/she must sign the Authorization Form.

In addition to the above, an authorized representative(s) who is an employee of your office should **only** complete this form. Should your office utilize a billing firm or agency, a letter signed by yourself must be submitted indicating the name(s) of those individuals you have authorized to sign. The name(s) should be printed and then the actual signature affixed by that individual. The letter should contain the name of the billing firm or agency which has been approved to provide your billing.

If your application is for the group please provide the GROUP NAME in the Provider Name field. If the application is for an individual please provide the Individual Provider name in the Provider name field.

Note: Only Originals. No Faxes or Copies are accepted.

Provider Name:		
Provider ID #:		NPI#:
Address:		
City:	State:	Zip:

Please Print or Type	
Full Name	**Actual Signature(s)**

RETURN TO:

Molina Medicaid Solutions
Attn: Provider Enrollment Unit
P.O. Box 4804
Trenton, NJ 08650-4804