Producer of Record
Change Request Form

Member Information

Policy Holder Name: _____
Last *First* *M.I.*

Member ID: _____ State: _____

Requested Effective Date: _____

Reason for change: _____

New Agent information

Current POR Name: _____ Writing#: _____
(Please Print)

New POR Name: _____ Writing#: _____
(Please Print)

Disclaimer and Signature

This letter requests that the above stated Producer of Record has the authority to represent this member for all lines of coverage with Molina Healthcare. This form replaces any prior authorization that may have been previously completed for purposes of Producer of Record designation. I certify that I am the policyholder stated above in the "Member Information" section and that all information contained herein is complete and accurate to the best of my knowledge. I understand that Molina reserves the right to make the final determination of approval or disapproval of this request, and that the effective date may be delayed due to circumstances beyond the control of Molina. I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

Submit completed form to:

Email: MCREnrollment@MolinaHealthcare.com or Fax: (866) 891-2422

Office Use Only

Current POR Name: _____ Writing# _____

New POR Name: _____ Writing# _____

Effective Date: _____

If you have any questions or concerns, please contact Molina Broker Services at (866) 440-9788