PASSPORT HEALTH PLAN

5100 COMMERCE CROSSINGS DRIVE
LOUISVILLE, KY 40229
502-585-7900 / 800-578-0603
WWW.PASSPORTHEALTHPLAN.COM

ADDING A PRACTITIONER FORM

Does the practitioner see members in an office setting? ____Y ____N

Practitioner's primary county location _____

Please check one:

____ Practitioner is a PCP

____ Practitioner is a Specialist

Please add _____, _____ Effective _____
Name Title Date

Practitioner NPI # _____, Practitioner Taxonomy Code _____

Practitioner Medicare # _____, Practitioner Gender ____M ____F

Practitioner Social Security # _____, Practitioner Date of Birth _____

Practitioner's Specialty _____

Practitioner CAQH # _____, Practitioner Office Hours: _____

_____

Please Check One:

____ Practitioner has an active KY Medicaid ID. The Medicaid ID is _____

____ Practitioner has applied for a KY Medicaid ID. Medicaid ID is pending.

____ Please assist in obtaining Practitioner's Medicaid ID. MAP 811 is included.

Practice Name _____

Practice NPI _____, Practice Taxonomy Code _____

Passport Health Plan Group ID _____

If this is a new solo set up or a new group set up, a "Practice Demographic Form" is required to process this practitioner add request.

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Please check one:

____ Practitioner practices only at primary address

____ Practitioner practices at all addresses

____ Other (List is attached with practice addresses specified)

Please check one:

____ Group has an active KY Medicaid ID. The group Medicaid ID is _____

____ Group has applied for a KY Medicaid ID. Group Medicaid ID is pending.

____ Please assist in obtaining Group's Medicaid ID. MAP 811 application is included.

Tax ID _____, Tax Name _____

Tax Address _____

Tax City _____ Tax State _____ Tax Zip Code _____

Tax Phone _____

PANEL INFORMATION (IF APPLICABLE)

Age Limitations _____ MIN _____ MAX

Gender Limitations ____Male Only ____ Female Only ____ Both

Group Panel Status ____ OPEN ____ CLOSED

VOLUNTARY QUESTIONAIRE

Practitioner Ethnicity ____ Non-Hispanic ____ Hispanic ____ Unknown

Practitioner Race: ____Black or African American ____ American Indian / Alaska Native

____ White ____ Native Hawaiian / Other Pacific Islander ____ Other

Would any practitioners in the practice like to be contacted to join a Passport Health Plan Committee?

____ Yes ____ No

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CREDENTIALING CONTACT INFORMATION

Credentialing Contact Name _____ Phone _____

Fax Number _____ Email Address _____

Address _____

City _____ State _____ Zip Code _____

IMPORTANT INFORMATION

- To expedite processing, please remember:
  - Attach a W9
  - Attach a MAP 811 with required attachments, if applicable
  - Assure Passport Health Plan as access to retrieve the practitioner's CAQH
- This form can be returned via email to Passport.Credentialing@passporthealthplan.com, via fax at (502) 585-7987, or via mail at: Attention: Provider Enrollment, 5100 Commerce Crossings Drive, Louisville KY 40229
- Submit an Adding a Practitioner Form for each set up practitioner needs to be affiliated with.
- KY Medicaid Requirements by provider type are available at http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm.
- KY Medicaid Enrollment Forms are available at http://chfs.ky.gov/dms/provEnr/Forms.htm.
- Passport Health Plan notices will be sent electronically via POIS (Passport Online Information Service) and posted on our website at http://www.passporthealthplan.com/.
- For questions regarding this form, you may contact Provider Enrollment at Passport.Credentialing@passporthealthplan.com.

_____ _____
Name of person submitting request Title

_____
Phone

_____
Office Email

For credentialing information, please call (502) 588-8578
or email passport.credentialing@passporthealthplan.com