MAIL TO:
PASSPORT HEALTH PLAN
Attn: Provider Enrollment
5100 Commerce Crossings Drive
Louisville, KY 40229
(502) 588-8578
Fax: (502) 585-7987
Passport.Credentialing@passporthealthplan.com

Adding a Practitioner to a Participating Group

(use one form per group attachment)

FACILITY BASED PRACTITIONER? ☐ YES ☒ NO

(Does this practitioner provide services strictly in an inpatient or ER/facility setting?)

Please add _____, _____ **to the group indicated below, effective** _____

Name *Title* *Date*

Individual NPI #: _____ **Taxonomy Code:** _____

Individual KY Medicaid #: _____

*(The KY Medicaid # must be active. See **Requirements** on 2nd page.)*

MAP Forms Provider Directly Sent to Kentucky Medicaid:

☒ MAP 811
☒ Medicaid MAP 347

Medicare #: _____

Social Security #: _____ **Date of Birth:** _____

Practitioner's Specialty: _____ **CAQH #:** _____

(Include any Subspecialty)

Provider Group Name: Transformations hope for today's families LLC

Add Practitioner to:

- **Primary location only:** ☒ YES ☐ NO
- **All locations:** ☐ YES ☐ NO
- **Other:** **Attach a list of specific locations**

Grp NPI #: 1427229483 **Grp KY MAID #:** 7100269220 **Grp Taxonomy Code:** 251s0000X

Passport group #: pending **Tax ID #:** 61-1351752

*If the group is new, please complete and submit a "**New Group Set-Up Form**" and indicate pending for the Passport group number.*

PANEL LIMITATIONS (If Applicable)

Please confirm the Panel Limitations that should be placed on this practitioner. Please remember that any limitations should be consistent with what has already been established for your group:

AGE LIMITATIONS: none _____ none _____ ☐ Male Only ☐ Female Only ■ Both

Min *Max*

GROUP PANEL STATUS: ■ Open ☐ Closed **MAXIMUM PANEL NUMBER:** no limit _____

CURRENT AFFILIATIONS (If Applicable)

Please indicate from which provider group(s) the practitioner should be terminated upon joining your group.

Group Name: _____ **Group Tax ID #:** _____

Group Name: _____ **Group Tax ID #:** _____

REQUIREMENTS

To expedite your request, please include:

- **A signed W-9 form with the appropriate tax information.**
- **A completed KY Medicaid MAP 811 form, if applicable.**
- **A completed KY Medicaid MAP 347 form which will connect the practitioner to your Group KY Medicaid ID #, if applicable.**
- **KY Medicaid MAP forms are available at http://chfs.ky.gov/dms/provEnr/Provider+Types.htm**
- **Plan notices will be sent electronically via POIS (Passport Online Information Service) and posted on the Plan's website.**

Teresa Lloyd _____ 502-905-9494 _____ _____

Name of person submitting this request *Telephone Number* *Date*

Email Address: tlloyd@transformationsllc.net _____

Any questions regarding this form, please call the Provider Enrollment department at (502) 588-8578 or you may email us at Passport.Credentialing@passporthealthplan.com.