This form is applicable for **Medicaid** AND **Passport Advantage** provider networks. **YOU ONLY NEED TO SUBMIT THIS FORM ONE (1) TIME.**

PASSPORT HEALTH PLAN PASSPORT ADVANTAGE (HMO SNP)

ADDING A PRACTITIONER FORM

Must complete entire form for processing. For credentialing information, please call 502-588-8758 or email passport.credentialing@passporthealthplan.com

Provider _____, _____
LAST NAME, FIRST NAME TITLE

Practitioner NPI # _____ Practitioner Gender: ☐ M ☐ F

Practitioner Medicare # _____(Required if applicable)

Have you opted out of Medicare? ☐ Yes ☐ No

Practitioner SSN # _____ Practitioner

DOB _____

Practitioner's Specialty _____

Does the Practitioner specialize in alcohol & substance abuse? ☐ Yes ☐ No

- If yes, is practitioner a certified prescriber of Burenorphine/Opiod treatment? ☐ Yes ☐ No
- Do you prescribe Burenorphine/Opiod treatment at this location? ☐ Yes ☐ No
- For all Burenorphine/Opiod treatment prescribers: **A copy of your DEA with an "X" in the DEA must be attached to this form**

Practitioner CAQH # _____

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.

GROUP AFFILIATIONS

Please include me in the following networks: ❑ Medicaid ❑ Medicaid AND Medicare

Effective Date _____

Group Name _____

Select 1: *(required)* ❑ PCP Group ❑ Specialist Group

Select 1: *(if applicable)* ❑ Urgent Care ❑ Walk-In Clinic ❑ Express Care Clinic
❑ CMHC ❑ BHSO ❑ FQHC ❑ RHC

Group NPI _____

Group primary address: _____ City: _____ State:_____ Zip:_____

Phone Number:_____Fax Number: _____Office Hours: _____

Passport Health Plan Group ID *(Required if an existing Passport Group)* _____

Does your group use an Electronic Medical Record (EMR) System? ❑ Yes ❑ No

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.

Does the practitioner provide face-to-face direct care services to members in an office setting?

❑ Yes ❑ No *If no, explain* _____

Please check one:

❑ Practitioner is a PCP (A practitioner who accepts member assignment to provide continuous care)
❑ Practitioner is a Specialist

Please check one:

❑ Practitioner practices only at primary address
❑ Practitioner practices at all group addresses
❑ Other (List is attached with practice addresses specified)

Please check one:

❑ Group has an active KY Medicaid ID. The Medicaid ID is _____
❑ Group has applied for a KY Medicaid ID. Medicaid ID is pending.
❑ Please assist in obtaining Group's Medicaid ID. MAP 811 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

Currently accepting new Medicaid patients: ❑ YES ❑ NO

Currently accepting new Medicare patients: ❑ YES ❑ NO

If more than 3 group affiliations, please add additional group information and attach to this form

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Tax ID _____ Tax Name _____ Tax Address _____

Tax City _____Tax State _____ Tax Zip Code _____ Tax Phone _____

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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

CREDENTIALING CONTACT INFORMATION

Credentialing Contact Name _____ Phone _____

Fax _____ Email _____

Address _____

City _____ State _____ Zip Code_____

IMPORTANT INFORMATION

To expedite processing please remember:

- Passport Health Plan does not currently enroll providers who are in their residency. Providers who are currently in the residency program may choose to register with Passport Health Plan as a non-participating provider. The registration for non-participating providers can be located at www.passporthealthplan.com.
- Attach a W9
- Attach a MAP 811 with required attachments, if applicable
- Assure Passport Health Plan has access to retrieve the practitioner's CAQH
- This form can returned to 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 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.