

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



PROVIDER TAX ID CHANGE REQUEST

FAX: (502) 585-8200 -OR- **MAIL:** Passport Health Plan
ATTN: Provider Contracting Department
5100 Commerce Crossings Drive, Louisville, KY 40229

Group Name: _____

Tax ID: _____

Effective Date: _____

Old Group Name: _____

Old Tax ID: _____

Please review definitions below and select the one that applies:

Liability Transferred to / Assumed by New Tax Entity

The new Tax Identification Number (TIN or EIN) continues to belong to the same entity (health system, facility, group and /or practitioner). Tax payment liability is “transferred” to the new entity.

Liability Not Transferred to / Not Assumed by New Tax Entity

The new Tax Identification Number belongs to an entity (health system, facility, group and /or practitioner) that is different from the owner of the previous Tax Identification Number. Tax payment liability is “not transferred” to the new entity.

Will Tax payment liability be transferred to the new entity? Yes No

Please submit a W9 with your change request.

Signature: _____

Date: _____

Phone: _____