

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



# PRACTICE DEMOGRAPHIC FORM

Please indicate which networks you are contracted for:  Medicaid  Medicaid AND Medicare

Practice NPI \_\_\_\_\_

Practice Tax ID \_\_\_\_\_

Practice Name \_\_\_\_\_

Primary Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Primary Phone \_\_\_\_\_ Primary Fax \_\_\_\_\_

## REMIT ADDRESS

Remit Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Remit Phone \_\_\_\_\_ Remit Fax \_\_\_\_\_

## OFFICE HOURS

Monday – Friday \_\_\_\_\_  
FROM TO

OR

Specified Days and Times: \_\_\_\_\_

## PRACTICE LIMITATIONS IF APPLICABLE

Male only  Female only  
 Min age \_\_\_\_\_  Max age \_\_\_\_\_

Other: \_\_\_\_\_

## PLEASE NOTE:

The Practice Demographic Form cannot be processed without attaching "Adding a Practitioner Form(s)."

For credentialing information, please call 502-785-8281 or email [ProviderEnrollment@passport.evolenthealth.com](mailto:ProviderEnrollment@passport.evolenthealth.com) for Passport Health Plan or [MedicareEnrollment@passport.evolenthealth.com](mailto:MedicareEnrollment@passport.evolenthealth.com) for Passport Advantage.