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

PROVIDER INFORMATION CHANGE FORM

Provider Information Change Form
This form may be used to request changes to current demographic information.
Complete Part 1 ONLY if you are changing information to an individual provider.
Complete Part 2 ONLY if you are changing information to a group or facility.

Effective Date of Change Requested: ______________________
Requestor Name: __________________________________ Requestor Email: __________________________
Requestor Phone Number: ___________________________

PART 1
Individual Provider Change Request
Individual Provider Passport ID ____
Individual Provider NPI # ____
Individual Provider Name (as Passport has it today) ____

Complete only the fields that require a change.

Name: ____
**must attach a professional license with the provider's new name*

Date of Birth: ____
Reason for correction request: ____

SSN: ____
Reason for correction request: ____

PART 2
Group or Facility Change Request
Group or Facility Passport ID ____
Group or Facility NPI # ____
Group or Facility Name (as Passport has it today) ____

Complete only the fields that require a change.

Group or Facility Name: ____

Site Address Change

OLD SITE ADDRESS	NEW SITE ADDRESS
Street: ______________________	Street: ______________________
City, State, Zip: ______________________	City, State, Zip: ______________________
Phone: ______________________	Phone: ______________________
Fax: ______________________	Fax: ______________________
	Office Days & Hours of Operation: ______________

CONTINUED ON BACK

<table>
<tr><td>Remit Address Change
OLD REMIT ADDRESS
Street: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax: ____________________</td><td>NEW REMIT ADDRESS
Street: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax: ____________________</td></tr>
<tr><td>Tax Address Change *must attach a W9
OLD TAX ADDRESS
Street: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax: ____________________</td><td>NEW TAX ADDRESS
Street: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax: ____________________</td></tr>
<tr><td colspan="2">Group or Facility Email Address: ____________________</td></tr>
</table>

You may return the request via:

- **email** > ProviderEnrollment@passport.evolenthealth.com for Passport Health Plan or MedicareEnrollment@passport.evolenthealth.com for Passport Advantage.
- **fax** > 502-585-7987, or
- **mail** > Attn: Provider Enrollment 5100 Commerce Crossings Dr. Louisville, KY 40229.

If you have questions regarding this form you may email ProviderEnrollment@passport.evolenthealth.com or call 502-785-8281.

**Indicates there is a required attachment for the request to be processed.*

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