

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



PROVIDER TERMINATION REQUEST FORM

Please complete this form and return to Passport Health Plan via email to ProviderEnrollment@passport.evolutionhealth.com or MedicareEnrollment@passport.evolutionhealth.com for Passport Advantage or fax to (502) 585-7987.

Today's Date _____

I am requesting to terminate from the following networks: Medicaid AND Medicare Medicare only

I am requesting to terminate: An individual provider The entire practice

Check appropriate box:

Specialist PCP (Note: PCP panel re-assignment instructions must be included, as indicated below.)

Provider's Name: _____

Passport Provider #: _____ Provider's Kentucky Medicaid ID #: _____

Provider's NPI #: _____ Termination Date: _____

Group Name: _____

Group Plan #: _____ Group NPI #: _____ Group Tax ID #: _____

The reason for termination, please check only one box:

Resigned from practice Moved out-of-state Deceased Retired

Practice closed Leave of absence* Sabbatical* Dissatisfaction with plan**

Provider Transferred to _____ (Group Name)

Other _____ (Explain)

* In these instances, please provide a separate explanation of the details in the "Additional Information" section below for our Provider Enrollment Team (i.e. duration of absence for leave or sabbatical.)

** Your Passport contract requires a 90 day written notification. **Therefore, in accordance with your contract, your termination date with the plan will be 90 days from the receipt of this request.** Meanwhile, your panel will be closed to new members.

PCP Panel Re-assignment Instructions:

Passport member re-assignment.

Please re-assign member panel to:

PCP's Name: _____

NPI #: _____ PCP's Individual PHP#: _____

Additional Information: _____

Name of person completing form: (please print) _____

Signature: _____ Telephone Number: _____