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

PASSPORT ADVANTAGE (HMO SNP) PASSPORT HEALTH PLAN

ADDING A PRACTITIONER FORM

Must complete entire form for processing. For enrollment information, please call 502-785-8281 or email ProviderEnrollment@passport.evolenthealth.com or MedicareEnrollment@passport.evolenthealth.com

Is the provider in Residency? ☐ Yes *(see back page) ☐ No

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 _____

Practitioner's subspecialty _____ Subspecialty taxonomy _____

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

- If yes, is practitioner a certified prescriber of Burenorphone/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 # _____

Provider Website/URL _____

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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Effective Date _____

Group Name _____

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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

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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 ProviderEnrollment@passport.evolenthealth.com or MedicareEnrollment@passport.evolenthealth.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.

_____ _____

NAME OF PERSON SUBMITTING REQUEST TITLE

_____

PHONE

_____

OFFICE EMAIL

For enrollment information, please call 502-785-8281 or email ProviderEnrollment@passport.evolenthealth.com for Passport Health Plan or MedicareEnrollment@passport.evolenthealth.com for Passport Advantage.