

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



# GROUP/PROVIDER ADDITIONAL ADDRESS FORM

Must complete entire form for processing. For enrollment information, call 502-785-8281 or e-mail [ProviderEnrollment@passport.evolutethealth.com](mailto:ProviderEnrollment@passport.evolutethealth.com) for Passport Health Plan or [MedicareEnrollment@passport.evolutethealth.com](mailto:MedicareEnrollment@passport.evolutethealth.com) for Passport Advantage. Must include a W-9.

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

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

Practice Group ID #: \_\_\_\_\_

Practice NPI #: \_\_\_\_\_

Practice Tax ID #: \_\_\_\_\_

Group Additional Address: \_\_\_\_\_

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

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

Provider Website/URL: \_\_\_\_\_

Please list the provider's Name and provider ID number to add to location above:

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

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**PLEASE NOTE:** The additional address form is to add an additional address to a group that is already active with Passport and in our system.