

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  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

NEW SITE ADDRESS  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Office Days & Hours of Operation: \_\_\_\_\_

<b>Remit Address Change</b> OLD REMIT ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____	NEW REMIT ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____
<b>Tax Address Change</b> <i>*must attach a W9</i> OLD TAX ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____	NEW TAX ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____
Group or Facility Email Address: _____	

You may return the request via:

- email > [ProviderEnrollment@passport.evolutionhealth.com](mailto:ProviderEnrollment@passport.evolutionhealth.com) for Passport Health Plan or [MedicareEnrollment@passport.evolutionhealth.com](mailto:MedicareEnrollment@passport.evolutionhealth.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.evolutionhealth.com](mailto:ProviderEnrollment@passport.evolutionhealth.com) or call 502-785-8281.

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