PASSPORT ADVANTAGE (HMO SNP) PASSPORT HEALTH ★ PLAN

PRIMARY CARE PROVIDER PANEL CHANGE REQUEST

☐ **Medicaid** ☐ **Medicare** ☐ **Both**

Group Name: ______________________________

Passport Health Plan Group ID: ______________________________

Tax ID: ______________________________

Practitioners in Group:
(Attach listing if additional space needed)

Practitioner	Open Panel?
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N
______________________________	Y or N

Panel Restrictions (i.e. age, gender, etc.)

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Requestor's Email Address: ______________________________

Requestor's Name: ______________________________

Date: ______________________________

NOTE: Please return completed form to Provider Enrollment via fax at (502) 585-7987 or email ProviderEnrollment@passport.evolenthealth.com for Passport Health Plan or MedicareEnrollment@passport.evolenthealth.com for Passport Advantage.

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