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

REGISTRATION FOR NON-PARTICIPATING PROVIDERS

A. CONTACT INFORMATION

Contact Name: _____ Date: _____

Phone: _____ Fax: _____

Email address: _____

B. PERSONAL/PROFESSIONAL INFORMATION

a. Provider Specific

Last Name _____ First Name: _____ MI: _____ Title/Degree: _____

Specialty: _____ NPI Number: _____ Taxonomy Code: _____

SSN: _____ *Kentucky Medicaid Number: _____

*Required for payment of services rendered

State License Number: _____ State: _____ Medicare Number: _____

b. Group Specific

Group/Facility Name: _____

Specialty: _____ NPI Number: _____ Taxonomy Code: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____

State License Number: _____ State: _____ Medicare Number: _____

*Kentucky Medicaid Number: _____ *Required for payment of services rendered

C. BILLING INFORMATION:

Tax Identification Number: _____

Tax Name: _____

Billing Contact: _____ Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Please fax completed form along with a W-9 to : Provider Enrollment at 502-585-7987
or email to: ProviderEnrollment@passport.evolenthealth.com.

Passport Health Plan claims will not be processed without an active Kentucky Medicaid Number.
Questions? Please contact Provider Services at (800) 578-0775.

To apply for a Kentucky Medicaid Number, please visit:
http://chfs.ky.gov/dms/provenr/application+information.htm