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

Is the provider currently in their residency program? ☐ Yes * ☐ No

* 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.

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 _____ Specialty Taxonomy_____

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 # _____

Tax ID _____ Tax Name _____

Individual Medicaid (Check one that applies):

☐ Individual Medicaid ID is active. Active Medicaid ID is _____

☐ Group has applied for the provider's individual Medicaid ID. Individual Medicaid ID is pending.

☐ Please assist in obtaining Practitioner's Medicaid ID. MAP 811 is included.

GROUP AFFILIATIONS

Group Name _____

Select 1: *(if applicable)* ☐ Urgent Care ☐ Walk-In Clinic ☐ Express Care Clinic
☐ CMHC ☐ BHSO ☐ FQHC ☐ RHC

Group NPI _____

Office Hours:

Sunday: _____ Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____

Group primary address*: _____ City: _____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

*PO BOX is not acceptable

*Please see Additional Service Locations Page

Does your group use an Electronic Medical Record (EMR) System? ☐ Yes ☐ No

Does your group want to be included in the directory? ☐ Yes ☐ No

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

Group Medicaid (Please check one):

☐ Group Medicaid ID is active. Active MAID is _____
☐ Group has applied for a Group Medicaid ID. Group Medicaid ID is pending.
☐ Group request Passport Health Plan to submit MAP 811. MAP 811 is included.

Remit Information:

Remit Address _____

City _____ State _____ Zip Code _____ County_____

Remit Phone _____ Remit Fax _____

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

Please list only address the individual provider practices at minimally once monthly. Should the provider treat a member on a coverage basis, the additional service location will be added via the claim submission. The additional service location will reflect the effective date of the loaded primary address of the corresponding group NPI.

Additional Service Location #1:

_____

City _____ State _____ Zip Code _____ County_____

Primary Phone _____ Primary Fax _____

Office Hours: Sunday: _____ Monday: _____ Tuesday: _____

Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____

Practice Limitations if Applicable:

☐ Male Only ☐ Female Only ☐ MIN age _____ ☐ MAX age _____

Other: _____

Additional Service Location #2:

_____

City _____ State _____ Zip Code _____ County_____

Primary Phone _____ Primary Fax _____

Office Hours: Sunday: _____ Monday: _____ Tuesday: _____

Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____

Practice Limitations if Applicable:

☐ Male Only ☐ Female Only ☐ MIN age _____ ☐ MAX age _____

Other: _____

Additional Service Location #3:

_____

City _____ State _____ Zip Code _____ County_____

Primary Phone _____ Primary Fax _____

Office Hours: Sunday: _____ Monday: _____ Tuesday: _____

Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____

Practice Limitations if Applicable:

☐ Male Only ☐ Female Only ☐ MIN age _____ ☐ MAX age _____

Other: _____

Additional Service Location #4:

_____

City _____ State _____ Zip Code _____ County_____

Primary Phone _____ Primary Fax _____

Office Hours: Sunday: _____ Monday: _____ Tuesday: _____

Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____

Practice Limitations if Applicable:

☐ Male Only ☐ Female Only ☐ MIN age _____ ☐ MAX age _____

Other: _____

Additional Service Location #5:

_____

City _____ State _____ Zip Code _____ County_____

Primary Phone _____ Primary Fax _____

Office Hours: Sunday: _____ Monday: _____ Tuesday: _____

Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____

Practice Limitations if Applicable:

☐ Male Only ☐ Female Only ☐ MIN age _____ ☐ MAX age _____

Other: _____

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:

- Enrollment into the Passport Advantage Medicare Line of Business will be completed for providers associated with Tax IDs that have a Passport Advantage Amendment
- Assure Passport Health Plan has access to retrieve the practitioner's CAQH
- This form can be returned by the following options:
  - Email to ProviderEnrollment@passport.evolenthealth.com
  - Fax to 1-800-470-8714
  - Mail to: **Attention: Provider Enrollment 5100 Commerce Crossings Drive Louisville, KY 40229**

DID YOU KNOW?

KY DMS has launched the KY MMPA Portal. KY MPPA and Partner Portal are the same application. KY MPPA is the new DMS electronic enrollment, maintenance, and revalidation process. Providers and Credentialing agents can use KY MPPA instead of the current paper process (MAP forms). Additional information can be found at https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/mppa.aspx.

_____ _____

NAME OF PERSON SUBMITTING REQUEST TITLE

_____

PHONE

_____

OFFICE EMAIL

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