

REGISTRATION FOR NON-PARTICIPATING PROVIDERS

A. CONTACT INFORMATION

Contact Name: _____ Date: _____
Phone: _____ Fax: _____
Email address: _____

B. PRACTICE INFORMATION

Last Name _____ First Name: _____ MI: _____ Title/Degree: _____
Specialty: _____ NPI Number: _____ Taxonomy Code: _____

Group/Facility Name: _____
Specialty: _____ NPI Number: _____ Taxonomy Code: _____

Physical Address: _____
City: _____ State: _____ Zip: _____ County: _____
Phone: _____ Fax: _____ SSN: _____

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

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.evolutionhealth.com.

Passport Health 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>

OFFICE USE ONLY – PROVIDER ID NUMBER ASSIGNMENT

Date Reviewed: _____ Assigned PM Rep: _____
Plan ID #: _____ Effective Date: _____