REGISTRATION OF LOCUM TENENS PHYSICIAN

The maximum time may not exceed sixty (60) continuous days.

I certify and attest, by my signature below, under penalty of perjury, that the information contained herein is true and faithful.

This physician is the **TEMPORARY REPLACEMENT** who applies and will actually perform the services on a short term basis.	This physician will be **ABSENT** during the billing and will not perform the services.
Applicant (Locum Tenens Provider) Full Name	Regular Physician Full Name
Permanent Address 1 (May not use a PO Box)	Office Address 1 (May not use a PO Box)
Address 2	Address 2
City, State, Zip	City, State, Zip
Social Security Number	Specific Duration – Not to exceed 60 consecutive days: MM/DD/YY to MM/DD/YY
NPI # Exp. date DEA # Exp. date	NPI # Exp. date DEA # Exp. date
Kentucky Medical License Number	Passport Health Plan Provider ID Number
Is a CONTRACT AGENCY involved in this placement? ☐ NO ☐ YES – If yes, please supply name and address of agency: Address 1 Address 2 City, State, Zip To my knowledge, I attest that I am not subject to any of the following: • A pending criminal or civil investigation regarding the provision of health care services; • Formal disciplinary sanctions from any board or professional association pursuant to KRS311.565; and/or • A federal or state sanction or penalty that would prevent me from participation in Medicare or Medicaid.	CHECK OFF REQUIRED ATTACHMENTS: ☐ Copy of valid physician license, DEA certificate, and a copy of any applicable board certification for the locum tenens physician ☐ PROOF of malpractice insurance coverage for the locum tenens physician for period of physician substitution **The Q-6 Modifier must be used for billing services performed by a locum tenens physician.** The holder of the valid provider number is required to bill the services of any locum tenens physician by utilizing the Health Care Procedure Coding System with the procedure modified code Q-6 in item 24d of form HCFA-1500 for every procedure performed by the locum tenens physician. Failure to bill correctly may be considered a violation of the terms of the Provider Agreement.
Signature (locum tenens) Date	Signature (regular physician) Date

RETURN THIS FORM TO:

FAX: (502) 585-6060	MAIL: Passport Health Plan Attn: Provider Relations 5100 Commerce Crossings Drive Louisville, KY 40229	