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)

	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.)

_____

_____

_____

Requestor's Email Address: _____

Requestor's Name: _____

Date: _____

NOTE: Please return completed form to Provider Enrollment via fax at (502) 585-7987 or email passport.credentialing@passporthealthplan.com.