PASSPORT HEALTH PLAN

CLAIM ISSUE FORM

Passport Health Plan
Attn: Claims Unit
P.O. Box 7114
London, KY 40742
Phone: 800-578-0775
Fax: 502-585-8339

PROVIDER INFORMATION	
Date:	Provider ID:
Provider Name:	Submitted By:
Contact Number:	

CLAIM/MEMBER INFORMATION	
Member Name:	Member ID:
Date of Service:	Total Billed Amount:
Claim Number:	CPT/HCPCS in Question:

CLAIM/MEMBER INFORMATION

Tell us what type of inquiry: ☐ Overpayment ☐ Underpayment

Please explain the issue you are having with the claim and/or reason for recoup: