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

PRACTICE DEMOGRAPHIC FORM

Please indicate which networks you are contracted for: ❑ Medicaid ❑ Medicaid AND Medicare

Practice NPI _____

Practice Tax ID _____

Practice Name _____

Primary Address _____

City _____ State _____ Zip Code _____ County _____

Primary Phone _____ Primary Fax _____

REMIT ADDRESS

Remit Address _____

City _____ State _____ Zip Code _____ County _____

Remit Phone _____ Remit Fax _____

OFFICE HOURS

Monday – Friday _____ _____
FROM TO

OR

Specified Days and Times: _____

PRACTICE LIMITATIONS IF APPLICABLE

❑ Male only ❑ Female only
❑ Min age _____ ❑ Max age _____

Other: _____

PLEASE NOTE:

The Practice Demographic Form cannot be processed without attaching "**Adding a Practitioner Form(s)**."

For credentialing information, please call 502-588-8578 or email passport.credentialing@passporthealthplan.com.