

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



# ADDING A PRACTITIONER FORM

**Must complete entire form for processing. For enrollment information, please call 502-588-8758 or email [provider.enrollment@passporthealthplan.com](mailto:provider.enrollment@passporthealthplan.com)**

Is the provider a resident?  Yes \*(see back page)  No

Provider \_\_\_\_\_, \_\_\_\_\_  
LAST NAME, FIRST NAME TITLE

Practitioner NPI # \_\_\_\_\_ Practitioner Gender:  M  F

Practitioner Medicare # \_\_\_\_\_ (Required if applicable)

Have you opted out of Medicare?  Yes  No

Practitioner SSN # \_\_\_\_\_ Practitioner DOB \_\_\_\_\_

Practitioner's Specialty \_\_\_\_\_

Practitioner's subspecialty \_\_\_\_\_ Subspecialty taxonomy \_\_\_\_\_

Does the Practitioner specialize in alcohol & substance abuse?  Yes  No

- If yes, is practitioner a certified prescriber of Burenorphine/Opiod treatment?  Yes  No
- Do you prescribe Burenorphine/Opiod treatment at this location?  Yes  No
- For all Burenorphine/Opiod treatment prescribers: **A copy of your DEA with an "X" in the DEA must be attached to this form**

Practitioner CAQH # \_\_\_\_\_

**Please check one:**

- Practitioner has an active KY Medicaid ID. The Medicaid ID is \_\_\_\_\_
- Practitioner has applied for a KY Medicaid ID. Medicaid ID is pending.
- Please assist in obtaining Practitioner's Medicaid ID. MAP 811 is included.

## GROUP AFFILIATIONS

Please include me in the following networks:  Medicaid  Medicaid AND Medicare

Effective Date \_\_\_\_\_

Group Name \_\_\_\_\_

Select 1: *(required)*  PCP Group  Specialist Group

Select 1: *(if applicable)*  Urgent Care  Walk-In Clinic  Express Care Clinic  
 CMHC  BHSO  FQHC  RHC

Group NPI \_\_\_\_\_

Group primary address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Office Hours: \_\_\_\_\_

Passport Health Plan Group ID *(Required if an existing Passport Group)* \_\_\_\_\_

Does your group use an Electronic Medical Record (EMR) System?  Yes  No

***If this is a new solo set up or a new group set up a "Practice Demographic Form" is required to process this practitioner add request.***

Does the practitioner provide face-to-face direct care services to members in an office setting?

Yes  No If no, explain \_\_\_\_\_

### **Please check one:**

- Practitioner is a PCP (A practitioner who accepts member assignment to provide continuous care)  
 Practitioner is a Specialist

### **Please check one:**

- Practitioner practices only at primary address  
 Practitioner practices at all group addresses  
 Other (List is attached with practice addresses specified)

### **Please check one:**

- Group has an active KY Medicaid ID. The Medicaid ID is \_\_\_\_\_  
 Group has applied for a KY Medicaid ID. Medicaid ID is pending.  
 Please assist in obtaining Group's Medicaid ID. MAP 811 is included.

Tax ID \_\_\_\_\_ Tax Name \_\_\_\_\_ Tax Address \_\_\_\_\_

Tax City \_\_\_\_\_ Tax State \_\_\_\_\_ Tax Zip Code \_\_\_\_\_ Tax Phone \_\_\_\_\_

## **PANEL INFORMATION (IF APPLICABLE)**

Age Limitations:  MIN  MAX

Gender Limitations:  Male Only  Female Only

Currently accepting new Medicaid patients:  YES  NO

Currently accepting new Medicare patients:  YES  NO

***If more than 3 group affiliations, please add additional group information and attach to this form***

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## VOLUNTARY QUESTIONNAIRE

**Practitioner Ethnicity:**  Non-Hispanic  Hispanic  Unknown

**Practitioner Race:**  Black or African American  American Indian/Alaska Native  White

Native Hawaiian/Other Pacific Islander  Other: \_\_\_\_\_

Would any practitioners in the practice like to be contacted to join a Passport Health Plan Committee?

Yes  No

## CREDENTIALING CONTACT INFORMATION

Credentialing Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## IMPORTANT INFORMATION

To expedite processing please remember:

- \* Passport Health Plan does not currently enroll providers who are in their residency. Providers who are currently in the residency program may choose to register with Passport Health Plan as a non-participating provider. The registration for non-participating providers can be located at [www.passporthealthplan.com](http://www.passporthealthplan.com).
- Attach a W9
- Attach a MAP 811 with required attachments, if applicable
- Assure Passport Health Plan has access to retrieve the practitioner's CAQH
- This form can returned to via email to [Provider.enrollment@passporthealthplan.com](mailto:Provider.enrollment@passporthealthplan.com), via fax at 502-585-7987, or via mail at: **Attention: Provider Enrollment 5100 Commerce Crossings Drive Louisville, KY 40229**
- Submit an Adding a Practitioner Form for each set up practitioner needs to be affiliated with.
- KY Medicaid Requirements by provider type are available at <http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm>.
- KY Medicaid Enrollment Forms are available at <http://chfs.ky.gov/dms/provEnr/Forms.htm>.
- Passport Health Plan notices will be sent electronically via POIS (Passport Online Information Service) and posted on our website at [www.passporthealthplan.com](http://www.passporthealthplan.com).

\_\_\_\_\_  
NAME OF PERSON SUBMITTING REQUEST

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
OFFICE EMAIL

**For enrollment information, please call 502-588-8578  
or email [provider.enrollment@passporthealthplan.com](mailto:provider.enrollment@passporthealthplan.com).**