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

PROVIDER INFORMATION CHANGE FORM

Provider Information Change Form
This form may be used to request changes to current demographic information.
Complete Part 1 ONLY if you are changing information to an individual provider.
Complete Part 2 ONLY if you are changing information to a group or facility.

Effective Date of Change Requested: _____

Requestor Name: _____ Requestor Email: _____

Requestor Phone Number: _____

PART 1

Individual Provider Change Request

Individual Provider Passport ID _____

Individual Provider NPI # _____

Individual Provider Name (as Passport has it today) _____

Complete only the fields that require a change.

Name: _____

**must attach a professional license with the provider's new name*

Date of Birth: _____

Reason for correction request: _____

SSN: _____

Reason for correction request: _____

PART 2

Group or Facility Change Request

Group or Facility Passport ID _____

Group or Facility NPI # _____

Group or Facility Name (as Passport has it today) _____

Complete only the fields that require a change.

Group or Facility Name: _____

Site Address Change

OLD SITE ADDRESS

Street: _____

City, State, Zip: _____

Phone: _____

Fax: _____

NEW SITE ADDRESS

Street: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Office Days & Hours of Operation: _____

CONTINUED ON BACK

Remit Address Change **OLD** REMIT ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____	 **NEW** REMIT ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____
Tax Address Change **must attach a W9* **OLD** TAX ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____	 **NEW** TAX ADDRESS Street: _____ City, State, Zip: _____ Phone: _____ Fax: _____
Group or Facility Email Address: _____	

You may return the request via:

- **email** > provider.enrollment@passporthealthplan.com,
- **fax** > 502-585-7987, or
- **mail** > Attn: Provider Enrollment 5100 Commerce Crossings Dr. Louisville, KY 40229.

If you have questions regarding this form you may email provider.enrollment@passporthealthplan.com or call 502-588-8578.

**Indicates there is a required attachment for the request to be processed.*