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 TERMINATION REQUEST FORM

Please complete this form and return to Passport Health Plan via email to provider.enrollment@passporthealthplan.com or fax to (502) 585-7987 option 1.

Today's Date: _____

I am requesting to terminate from the following networks: ☐ Medicaid AND Medicare ☐ Medicare only

I am requesting to terminate: ☐ An individual provider ☐ The entire practice

Check appropriate box:

☐ Specialist ☐ PCP (Note: PCP panel re-assignment instructions must be included, as indicated below.)

Provider's Name: _____

Passport Provider #: _____ Provider's Kentucky Medicaid #: _____

Provider's NPI#: _____ Termination Date: _____

Group Name: _____

Group Plan #: _____ Group NPI #: _____ Group Tax ID #: _____

The reason for termination, please check only one box:

☐ Resigned from Practice ☐ Moved Out-of-State ☐ Deceased ☐ Retired

☐ Practice Closed ☐ Leave of Absence* ☐ Sabbatical* ☐ Dissatisfaction with Plan**

☐ Provider Transferred to _____ (Group Name)

☐ Other _____ (Explain)

* In these instances, please provide a separate explanation of the details in the "Additional Information" section below for our Provider Enrollment Team (i.e. duration of absence for leave or sabbatical.)

** Your Passport contract requires a 90 day written notifcation. **Therefore, in accordance with your contract, your termination date with the plan will be 90 days from the receipt of this request.** Meanwhile, your panel will be closed to new members.

PCP Panel Re-Assignment Instructions:

☐ Passport member re-assignment.

☐ Please re-assign member panel to:

PCP's Name: _____

NPI #: _____ PCP's Individual PHP#: _____

Additional Information: _____

_____

_____

Name of person completing form: (please print) _____

Signature: _____ Telephone Number: _____