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

GROUP/PROVIDER ADDITIONAL ADDRESS FORM

Must complete entire form for processing. For enrollment information, call 502-588-8758 option #1 or e-mail provider.enrollment@passporthealthplan.com. Must include a W-9.

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

Practice Name: _____

Practice Group ID #: _____

Practice NPI #: _____

Practice Tax ID #: _____

Group Additional Address: _____

City_____**State**_____**Zip Code**_____**County**_____

Phone _____ **Fax**_____

Provider Website/URL: _____

Please list the provider's Name and provider ID number to add to location above:

Provider Name: _____ **Provider ID #:** _____

Provider Name: _____ **Provider ID #:** _____

Provider Name: _____ **Provider ID #:** _____

Provider Name: _____ **Provider ID #:** _____

Provider Name: _____ **Provider ID #:** _____

Provider Name: _____ **Provider ID #:** _____

PLEASE NOTE: The additional address form is to add an additional address to a group that is already active with Passport and in our system.