Guide to Provider Forms

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED
Add a Provider to the group	• PIF – Complete Section A, Section N* *Section N can be copied when adding multiple providers
Terming a provider	• PIF – Complete Section A and Section J • Term letter on your organization's letterhead
Closing a service location(s)	• PIF – Complete Section A and Section H
Change Phone/Fax	• PIF – Complete Section A, Section F
Change the Pay-To/ Billing Address	• PIF – Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Change or add a service location	• PIF – Complete Section A, Section G
Add a new group to the same Tax Identification Number (TIN)	• PIF – Complete Section A • W-9 • Sample Claim Form (de-identified)
Change Group Name Only	• PIF – Complete Section A and Section D • Sample Claim Form (de-identified) • W-9
Change TIN only	• PIF – Complete Section A and Section B • W-9 • Sample Claim Form (de-identified)

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Individual Name Change	• PIF – Complete Section A and Section E
Provider Directory Update	• PIF – Complete Section A and Section L
Panel Update	• PIF – Complete Section A and Section K
Hospital Affiliations Update	• PIF – Complete Section A and Section M
Group/Provider NPI change	• PIF – Complete Section A and Section C
FORMS:	**FORM USAGE:**
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions and additions regarding participating providers to Passport Health Plan by Molina Healthcare.
W-9	This document is issued by the U.S. Internal Revenue Service (IRS). Passport uses it to update the TIN owner name, doing business as name, and Tax ID when received with a PIF.
Credentialing - Individual Providers	**YOU WILL NEED TO...**
If you have a CAQH number	Complete CAQH Provider Data Form. You also need to update and give Passport permission to review. Visit the website at http://www.caqh.org.
If you do not have a CAQH number	Go to http://www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Passport to review.

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Credentialing - Facilities and Other Providers	YOU WILL NEED TO ...
Including Hospitals, Ambulatory Surgical Centers, Home Health Agencies, Durable Medical Equipment (DME) Suppliers, SNFs, Urgent Care Centers, and Retail Clinics	Print, complete, fax, email or mail the Healthcare Delivery Organization Form. This form can be found on our website at www.passporthealthplan.com Passport Health Plan by Molina Healthcare Attention: Provider Contracts 5100 Commerce Crossings Drive Louisville, KY 40229 Fax# : (833) 529-1081 Email: contracting@passporthealthplan.com
CONTACT INFORMATION	If you have additional questions please contact Passport Health Plan by Passport's Provider Services Department at (800) 578-0775 between the hours of 7:30 a.m. to 6:00 p.m. CST, Monday through Friday.

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Provider Information Update Form (PIF)

Today's Date ___/___/___

This form and the associated documentation are required to notify Passport Health Plan of any changes to your group/practice information and/or to begin the credentialing process. This form is also available at **www.passporthealthplan.com.**

Type of Group: ☐ Medical Group ☐ Specialist ☐ PCP ☐ Hospital ☐ Urgent Care
☐ FQHC/RHC ☐ Behavioral Health ☐ PHO-IPA ☐ ASC ☐ Other

SECTION A

Current Group/Practice Information *(All fields in this section are required)*

Group/Practice Name: _____

Group/Practice Tax ID: _____ Group/Practice Medicaid #: _____

Group/Practice NPI #: _____ Contact Name: _____

Email address: _____ Contact Number: _____

Group/Practice Add, Name Change, Tax ID Number Change and NPI Change

If changing both the Group/Practice Name and the Tax ID Number, a new contract is required. Please contact Passport Provider Services at (800) 578-0775. A representative will be available to assist you Monday through Friday, 8:00 a.m. to 5:00 p.m. EST.

Return to first page.

SECTION B
Tax ID Number Change   Effective Date_____/_____/_____

Previous Tax ID Number _____ New Tax ID Number _____

Return to first page.

SECTION C

Group/Provider NPI Change

_____ **Group**   _____ **Individual**

Group/Provider Name: _____

Previous NPI: _____ New NPI: _____

Return to first page.

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SECTION D
Group/Practice Add or Change   Effective Date _____/_____/_____

Previous Group/Practice name: _____ Medicaid #: _____

New Group/Practice name: _____ Medicaid #: _____

Return to first page.

OTHER CHANGES

SECTION E
Individual Name Change

Previous Name: _____ New Name: _____

Provider NPI:_____

Return to first page.

SECTION F
Change Phone/Fax   Effective Date ____/____/_____

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

Return to first page.

SECTION G
___ **Add a Service Location** ___ **Change a Service Location**   Effective Date:____/____/_____

Previous Address   **New Address**

Address 1: _____ Address 1: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Phone Number: _____

Fax Number: _____ Fax Number: _____

Email: _____ Email: _____

                                        Office Hours: _____

Return to first page.

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SECTION H

___ **Closing a Service Location**   Effective Date:_____/_____/_____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Reason: (Required) _____

Authorizing Signature Printed: _____

   Authorizing Signature: _____

   Phone Number:_____Fax Number: _____

   Email Address: _____

   Date: _____/_____/_____

SECTION I

Billing Address Change   Effective Date:_____/_____/_____

<u>Previous Billing Information</u>   <u>New Billing Information</u>

Billing Contact: _____   Billing Contact: _____

Address 1: _____   Address 1: _____

Address 2: _____   Address 2: _____

City, State, Zip: _____   City, State, Zip: _____

Phone Number: _____   Phone Number: _____

Fax Number: _____   Fax Number: _____

• Is this a Notice Address Change? ____No ____Yes

The notice Address is the particular party's address for delivery or mailing of notice purposes.

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SECTION J
Terming a Provider

A termination letter is required on company letterhead including: name of the provider to be termed, group name, effective date of termination, reason for termination and address of practice location(s).

If terming provider is a PCP, who will assume patient panel?

Provider Name (Last, First, MI) _____Provider NPI:_____

SECTION K

Provider Name _____ Provider NPI: _____

Address: _____ City, State, Zip: _____

☐ PCP ☐ Specialist

Panel Update   Effective Date_____/_____/_____

_____ Existing Patients Only   _____ Close Panel to all Members   _____ Open Panel

Reason: (Required) _____

SECTION L
Provider Directory Update   Effective Date _____/_____/_____

_____ Include in Provider Directory   _____ Exclude from Provider Directory

Reason: (*Required*) _____

SECTION M
Hospital Affiliations Update   Effective Date_____/_____/_____

_____ Add Hospital Affiliation(s)   _____ Remove Hospital Affiliation(s)

Names of Hospital(s) _____

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☐ PAR application ☐ Non-PAR application

SECTION N

Provider Joining a Group/Practice   Effective Date: _____/_____/_____ Locum Tenen: _____Y ___N

Provider Name (Last, First, MI): _____

Provider Type (MD, DO, DC DDS, DPN, etc.): _____ Date of Birth: _____

Individual Provider NPI Number: _____ CAQH Provider Number: _____

Note: Please ensure the provider has completed and/or re-attested to the CAQH Application and has authorized Passport to access the provider's record on the CAQH website.

Office hours: _____ Include in directory: _____Y ___N

Is provider accepting new patients _____Y _____N   Open or closed panel (for PCPs)_____

Age Restrictions_____Gender Restrictions_____

For Physician Assistants only - Name of Supervising Physicians: _____

Does this practitioner provide face-to-face direct care servies to members in an office setting?"

_____

KY Medicaid Provider ID: _____

Specialty: _____ Secondary Specialty: _____

Applying as: ___ PCP   ___ Specialist   ___ Allied Health Professional

Board Certified: ___Yes ___No   Effective Date: _____/___/_____   Expiration Date: _____/___/_____

Certification Board: _____

Group/Practice Name: _____

Group/Practice Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

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NEW SECTION M
Requestor Contact information

Requestor Contact Name: _____   Phone Number: _____

Fax Number: _____   Email: _____

Address: _____   City, State, Zip: _____

If you have any questions, visit our website at www.passporthealthplan.com or call Provider Services at (800) 578-0775. Representatives are available to assist you Monday through Friday from 7:30 a.m. to 6:00 p.m.

Please mail, fax or email this form and supporting documentation to:

Passport by Molina Healthcare
ATTN Provider Network Administration
5100 Commerce Crossings Drive
Louisville, KY 40229
Fax# : (833) 529-1081
contracting@passporthealthplan.com

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