# Primary Care Provider Member Dismissal Form

## INCOMPLETE FORMS WILL NOT BE PROCESSED.

**Please complete one form per member. Dismissals will be made effective 30 days from the date of receipt. For more information regarding member dismissal policies please refer to the Provider Manual. Passport encourages providers to report missed or cancelled appointments to the Department for Medicaid Services via Kentucky HealthNet (KYMMIS).**
*denotes required fields

### Provider Information

*Provider Name: _____

*Provider TIN: _____ *Provider NPI: _____

*Address: _____

*Contact Name: _____ *Contact Phone Number: ( _____ ) _____ - _____

### Member Information

*Member First Name: _____ *Member Last Name: _____

*Member ID: _____ *Member DOB: _____

### *Dismissal Reason

**Please check one of the following, corresponding detail is required:**

☐ Incompatibility of the PCP/patient relationship

*Detail: _____

_____

☐ Inability to meet the medical needs of the member.

*Detail: _____

_____

☐ Member has not utilized a service within one year of enrollment in the PCP's practice.
Please list the six (6) attempts to contact member below:

1. *Date: _____ Method: _____
2. *Date: _____ Method: _____
3. *Date: _____ Method: _____
4. *Date: _____ Method: _____
5. *Date: _____ Method: _____
6. *Date: _____ Method: _____

☐ *Detail: _____

_____

***Date dismissal notification letter was sent to member:** _____

*Signature: _____

Printed Name: _____ Date: _____

Please note the effective date will be 30 days after the date Passport Health Plan receives the dismissal form and NOT the signature date.

Internal Use ONLY: Rec'd Date Rec'd By

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|---|---|
| | |

**Please submit to Provider Relations at:**

**Fax:** 502-585-6060
**Email:** ProviderRelations@passporthealthplan.com
**Mail:** Passport by Molina Healthcare
Attn: Provider Relations
PO Box 36030
Louisville, KY 40223





PASSPORT BY MOLINA HEALTHCARE