

Guide to Provider Forms

ACTION FOR THIS FORM	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
Terminating a provider	PIF – Complete Section A, Section J, Section O
Closing a service location(s)	PIF – Complete Section A, Section H, Section O
Change Phone/Fax	PIF – Complete Section A, Section F, Section O
Change the Pay-To/ Billing Address	- PIF – Complete Section A, Section I, Section O W-9 - Sample Claim Form (de-identified)
Change or add a service location	- PIF – Complete Section A, Section G, Section O - Note – If the new Service Location is also a new Billing NPI for the provider, please submit the “Request to Add New Provider Form” instead of the Provider Information Update Form
Change Group Name Only	- PIF – Complete Section A, Section D, Section O - Sample Claim Form (de-identified) W-9
Change TIN only	- PIF – Complete Section A, Section B, Section O W-9 - Sample Claim Form (de-identified)
Individual Name Change	PIF – Complete Section A, Section E, Section O
Provider Directory Update	PIF – Complete Section A, Section L, Section O
PCP/Specialist and Panel Updates	PIF – Complete Section A, Section K, Section O

Add or Change Taxonomy	PIF – Complete Section A, Section N, Section O
Change KY Medicaid ID number	PIF – Complete Section A, Section M, Section O
Group/Provider NPI change	- PIF – Complete Section A, Section C, Section O - If adding a new Group/Billing NPI, please submit a Request to Add New Provider Form or a Group Roster Template for the individual providers who will be billing under the new Group NPI. A W9 form is also required.
Didn't find your specific request?	If your specific type of request is not listed, you can complete section A of the form, and attach a letter on your company letter head with specific instructions on what information needs to be updated and submit along with any pertinent supporting documentation.
OTHER FORMS AVAILABLE:	FORM USAGE:
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions, and terminations regarding participating providers to Passport Health Plan by Molina Healthcare.
Request to Add New Provider Form	This form is used to: - Add new provider(s) to an existing group - Add a new group NPI and Provider(s) to the existing Tax Identification Number (TIN) * If TIN is not yet contracted, please submit a Provider Contract Request Form
Practitioner Application	This form is used for credentialing only when a provider does not have a CAQH account.
Provider Contract Request Form	This form is used to request a new contract for a group/entity that is not already contracted with Passport Health Plan by Molina Healthcare, or to request adding additional products or services not previously contracted.
Group Roster Template	Used to submit multiple provider additions on one form in an excel format

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 <u>PIF</u> , or to load a new Billing NPI when received with a <u>PAF</u> .
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.

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 Facility/HealthCare Delivery Organization (HDO)/Long Term Special Services (LTSS) Credentialing Application. Also, please include the Disclosure of Ownership and Control Form and a W9. These forms can be found on our website at www.passporthealthplan.com Passport Health Plan by Molina Healthcare Attention: Provider Contracts 2028 W. Broadway Louisville, KY 40203 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. 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 Health Plan Contract Managers at KY_Contract_Management@MolinaHealthCare.Com.

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SECTION B

Tax ID Number Change

Effective Date of Change ____/____/____

Previous Tax ID Number _____ New Tax ID Number _____

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SECTION C

Group/Provider NPI Change

Effective Date of Change ____/____/____

____ Group ____ Individual

Group/Provider Name: _____

Previous NPI: _____ New NPI: _____

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SECTION D

Group/Practice Add or Change

Effective Date of Change_____ / _____ / _____

Previous Group/Practice name: _____ Medicaid ID#: _____

New Group/Practice name: _____ Medicaid ID#: _____

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SECTION E

Individual Name Change

Effective Date of Change_____ / _____ / _____

Previous Name: _____ New Name: _____

Provider NPI: _____

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SECTION F

Change Phone/Fax

Effective Date of Change_____ / _____ / _____

Address: _____ City, State, Zip_____

Previous Phone Number: _____ New Phone: _____

Previous Fax Number: _____ New Fax: _____

SECTION G

Add or Change a Service Location

Effective Date of Change _____ / _____ / _____

(Select one) _____ Add a Service Location _____ Change a Service Location

(Select one) _____ Add/Change for Group and all providers _____ Add/Change for specific provider only

Provider Name* _____ Provider NPI _____

*If the New Location being added is a New Billing NPI for this provider, please submit a Provider Add Form (PAF)

At New Location: _____ PCP _____ Specialist (Select One) Will new location be listed in the directory? Y N

At New Location: _____ Existing Patients Only _____ Close Panel to all Members _____ Open Panel (Select all that apply)

Previous Service Location

New Service Location

Address 1: _____ Address 1: _____

Address 2: _____ Address 2: _____

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

Phone Number: _____ Phone Number: _____

Fax Number: _____ Fax Number: _____

Email Address: _____ Email Address: _____

Office Hours: _____

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SECTION H

Closing a Service Location

Effective Date of Change _____ / _____ / _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Reason (Required): _____

Authorizing Person Printed: _____

Authorizing Person Signature: _____

Authorizing Person Phone: _____ Fax: _____

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SECTION I

Billing Address Change

Effective Date of Change _____ / _____ / _____

Previous Billing Information

New Billing Information

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 _____ Yes _____ No

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

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SECTION J

Terminating a Provider

Name of Terminating Provider (Last, First, MI): _____

Provider NPI: _____ Date of Termination: _____

Reason for Termination: _____

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

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

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SECTION K

PCP/Specialist and Panel Updates

Effective Date of Change _____ / _____ / _____

(Specify Provider and Location to be Updated)

Provider Name _____ Provider NPI: _____

Address: _____ City, State, Zip: _____

_____ PCP _____ Specialist

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

Reason (Required): _____

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SECTION L

Provider Directory Update

Effective Date of Change _____ / _____ / _____

(Specify Provider and Location to be Updated)

Provider Name _____ Provider NPI: _____

Address: _____ City, State, Zip: _____

_____ Include in Provider Directory _____ Exclude from Provider Directory

Reason: (Required): _____

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SECTION M

Change KY Medicaid ID number

Effective Date of Change _____ / _____ / _____

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

Group/Facility Name: _____ Group/Facility NPI: _____

New KY Medicaid ID number: _____

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SECTION N

Add or Change Taxonomy

Individual Provider

Change Existing Taxonomy: Y N Add New Taxonomy: Y N Effective date of change: _____

Provider Name (Last, First, MI): _____ Provider Type (MD, DO, etc.): _____

Individual Provider NPI Number: _____ KY Medicaid Provider ID (MAID*): _____

*MAID number is required for payment of services rendered to Medicaid patients

New Taxonomy: _____

For Medicaid providers, the Taxonomy should match what is registered with Department for Medicaid Services (DMS)

Group/Facility

Change Existing Taxonomy: Y N Add New Taxonomy: Y N Effective date of change: _____

Group/Facility Name: _____

New Taxonomy: _____

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SECTION O

Requestor Contact information

Requestor Contact Name: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Address: _____ City, State, Zip: _____

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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 Health Plan by Molina Healthcare

ATTN **Provider Network Administration**

2028 W. Broadway

Louisville, KY 40203

Fax#: (833) 529-1081

contracting@passporthealthplan.com