This form is applicable for **Medicaid** AND **Passport Advantage** provider networks. **YOU ONLY NEED TO SUBMIT THIS FORM ONE (1) TIME.**

PASSPORT HEALTH PLAN PASSPORT ADVANTAGE (HMO SNP)

ADDING A PRACTITIONER FORM

Must complete entire form for processing. For credentialing information, please call 502-588-8758 or email passport.credentialing@passporthealthplan.com

Provider _____, _____
LAST NAME, FIRST NAME TITLE

Practitioner NPI # _____ Practitioner Gender: ☐ M ☐ F

Practitioner Medicare # _____(Required if applicable)

Have you opted out of Medicare? ☐ Yes ☐ No

Practitioner SSN # _____ Practitioner

DOB _____

Practitioner's Specialty _____

Does the Practitioner specialize in alcohol & substance abuse? ☐ Yes ☐ No

- If yes, is practitioner a certified prescriber of Burenorphine/Opiod treatment? ☐ Yes ☐ No
- Do you prescribe Burenorphine/Opiod treatment at this location? ☐ Yes ☐ No
- For all Burenorphine/Opiod treatment prescribers: **A copy of your DEA with an "X" in the DEA must be attached to this form**

Practitioner CAQH # _____

Please check one:

☐ Practitioner has an active KY Medicaid ID. The Medicaid ID is _____

☐ Practitioner has applied for a KY Medicaid ID. Medicaid ID is pending.

☐ Please assist in obtaining Practitioner's Medicaid ID. MAP 811 is included.

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GROUP AFFILIATIONS

Please include me in the following networks: ■ Medicaid ❑ Medicaid AND Medicare

Effective Date _____

Group Name Transformations hope for today's families LLC

Select 1: *(required)* ❑ PCP Group ■ Specialist Group

Select 1: *(if applicable)* ❑ Urgent Care ❑ Walk-In Clinic ❑ Express Care Clinic ❑ CMHC ❑ BHSO ❑ FQHC ❑ RHC

Group NPI 1427229483

Group primary address: 4010 Dupont Circle Suite 582 City: Louisville State: KY Zip: 40207

Phone Number: 502-899-5411 Fax Number: 502-899-5411 Office Hours: Mon-Fri 9 to 5

Passport Health Plan Group ID *(Required if an existing Passport Group)* 50071730

Does your group use an Electronic Medical Record (EMR) System? ■ Yes ❑ No

If this is a new solo set up or a new group set up a "Practice Demographic Form" is required to process this practitioner add request.

Does the practitioner provide face-to-face direct care services to members in an office setting?

■ Yes ❑ No *If no, explain* face to face direct care in-home and community

Please check one:

❑ Practitioner is a PCP (A practitioner who accepts member assignment to provide continuous care)
■ Practitioner is a Specialist

Please check one:

■ Practitioner practices only at primary address
❑ Practitioner practices at all group addresses
❑ Other (List is attached with practice addresses specified)

Please check one:

❑ Group has an active KY Medicaid ID. The Medicaid ID is _____
❑ Group has applied for a KY Medicaid ID. Medicaid ID is pending.
❑ Please assist in obtaining Group's Medicaid ID. MAP 811 is included.

Tax ID 611351752 Tax Name Transformations hope for today's famiies LLC Tax Address 4010 Dupont Circle Suite 582

Tax City Louisville Tax State KY Tax Zip Code 40207 Tax Phone 502-899-5411

PANEL INFORMATION (IF APPLICABLE)

Age Limitations: ❑ MIN ❑ MAX

Gender Limitations: ❑ Male Only ❑ Female Only

Currently accepting new Medicaid patients: ■ YES ❑ NO

Currently accepting new Medicare patients: ❑ YES ❑ NO

If more than 3 group affiliations, please add additional group information and attach to this form

GROUP AFFILIATIONS

Please include me in the following networks: ❑ Medicaid ❑ Medicaid AND Medicare

Effective Date _____

Group Name _____

Select 1: *(required)* ❑ PCP Group ❑ Specialist Group

Select 1: *(if applicable)* ❑ Urgent Care ❑ Walk-In Clinic ❑ Express Care Clinic
❑ CMHC ❑ BHSO ❑ FQHC ❑ RHC

Group NPI _____

Group primary address: _____ City: _____ State:_____ Zip:_____

Phone Number:_____Fax Number: _____Office Hours: _____

Passport Health Plan Group ID *(Required if an existing Passport Group)* _____

Does your group use an Electronic Medical Record (EMR) System? ❑ Yes ❑ No

If this is a new solo set up or a new group set up a "Practice Demographic Form" is required to process this practitioner add request.

Does the practitioner provide face-to-face direct care services to members in an office setting?

❑ Yes ❑ No *If no, explain* _____

Please check one:

❑ Practitioner is a PCP (A practitioner who accepts member assignment to provide continuous care)
❑ Practitioner is a Specialist

Please check one:

❑ Practitioner practices only at primary address
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Please check one:

❑ Group has an active KY Medicaid ID. The Medicaid ID is _____
❑ Group has applied for a KY Medicaid ID. Medicaid ID is pending.
❑ Please assist in obtaining Group's Medicaid ID. MAP 811 is included.

Tax ID _____ Tax Name _____ Tax Address _____

Tax City _____Tax State _____ Tax Zip Code _____ Tax Phone _____

PANEL INFORMATION (IF APPLICABLE)

Age Limitations: ❑ MIN ❑ MAX

Gender Limitations: ❑ Male Only ❑ Female Only

Currently accepting new Medicaid patients: ❑ YES ❑ NO

Currently accepting new Medicare patients: ❑ YES ❑ NO

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GROUP AFFILIATIONS

Please include me in the following networks: ❑ Medicaid ❑ Medicaid AND Medicare

Effective Date _____

Group Name _____

Select 1: *(required)* ❑ PCP Group ❑ Specialist Group

Select 1: *(if applicable)* ❑ Urgent Care ❑ Walk-In Clinic ❑ Express Care Clinic
❑ CMHC ❑ BHSO ❑ FQHC ❑ RHC

Group NPI _____

Group primary address: _____ City: _____ State:_____ Zip:_____

Phone Number:_____Fax Number: _____Office Hours: _____

Passport Health Plan Group ID *(Required if an existing Passport Group)* _____

Does your group use an Electronic Medical Record (EMR) System? ❑ Yes ❑ No

If this is a new solo set up or a new group set up a "Practice Demographic Form" is required to process this practitioner add request.

Does the practitioner provide face-to-face direct care services to members in an office setting?

❑ Yes ❑ No *If no, explain* _____

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Tax City _____Tax State _____ Tax Zip Code _____ Tax Phone _____

PANEL INFORMATION (IF APPLICABLE)

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Gender Limitations: ❑ Male Only ❑ Female Only

Currently accepting new Medicaid patients: ❑ YES ❑ NO

Currently accepting new Medicare patients: ❑ YES ❑ NO

If more than 3 group affiliations, please add additional group information and attach to this form

VOLUNTARY QUESTIONAIRE

Practitioner Ethnicity: ❑ Non-Hispanic ❑ Hispanic ❑ Unknown

Practitioner Race: ❑ Black or African American ❑ American Indian/Alaska Native ❑ White

❑ Native Hawaiian/Other Pacific Islander ❑ Other: _____

Would any practitioners in the practice like to be contacted to join a Passport Health Plan Committee?

❑ Yes ❑ No

CREDENTIALING CONTACT INFORMATION

Credentialing Contact Name Teri Lloyd Phone 502-905-9494

Fax 502-899-5411 Email tlloyd@transformationsllc.net

Address 4010 Dupont Circle Suite 582

City Louisville State KY Zip Code 40207

IMPORTANT INFORMATION

To expedite processing please remember:

- Passport Health Plan does not currently enroll providers who are in their residency. Providers who are currently in the residency program may choose to register with Passport Health Plan as a non-participating provider. The registration for non-participating providers can be located at www.passporthealthplan.com.
- Attach a W9
- Attach a MAP 811 with required attachments, if applicable
- Assure Passport Health Plan has access to retrieve the practitioner's CAQH
- This form can returned to via email to Passport.Credentialing@passporthealthplan.com, via fax at 502-585-7987, or via mail at: **Attention: Provider Enrollment 5100 Commerce Crossings Drive Louisville, KY 40229**
- Submit an Adding a Practitioner Form for each set up practitioner needs to be affiliated with.
- KY Medicaid Requirements by provider type are available at http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm.
- KY Medicaid Enrollment Forms are available at http://chfs.ky.gov/dms/provEnr/Forms.htm.
- Passport Health Plan notices will be sent electronically via POIS (Passport Online Information Service) and posted on our website at www.passporthealthplan.com.
- For questions regarding this form you may contact Provider Enrollment at Passport.Credentialing@passporthealthplan.com.

Teri Lloyd
NAME OF PERSON SUBMITTING REQUEST

owner
TITLE

502-905-9494
PHONE

tlloyd@transformationsllc.net
OFFICE EMAIL

For credentialing information, please call 502-588-8578 or email passport.credentialing@passporthealthplan.com.