

Locum Tenens for Participating PHP Providers

According to Passport Health Plan (PHP) policy, participating Plan providers may utilize the services of a locum tenens provider, under temporary circumstances, for a period of sixty (60) consecutive days or less. When locum tenens are required, participating PHP providers must register the substitute provider. This process must be completed prior to the provision of any services by a locum tenens provider.

Registering a Locum Tenens

To register a locum tenens provider, the participating PHP provider must complete a one-page Registration of Locum Tenens Physician form (located on page two of this Medical Office Notes). Both the participating PHP provider and the locum tenens provider must sign the form. To complete the registration process, the signed form must be returned to the Plan by mail or by fax as noted below:

Mail To:

Passport Health Plan
Attn: Contracting Department
305 W. Broadway
Louisville, Kentucky 40202

Fax To:

Attn: Contracting Department
(502) 585-8280

Billing for Services Provided by Locum Tenens

Services rendered by a locum tenens provider must be billed utilizing the absent provider's Plan ID number and the Q6 modifier with the applicable procedure code(s). The Q6 modifier signifies that the service was provided by a locum tenens provider. According to the PHP provider agreement, the absent provider remains liable and all contractual terms remain effective throughout the employ of a locum tenens provider.

Locum Tenens After 60 Days

If services by a locum tenens provider remain necessary beyond the period of sixty (60) consecutive days, the locum tenens or substitute provider must apply for participation with PHP and complete the credentialing process. Upon becoming credentialed with the Plan, the provider will be assigned a provider ID number for billing purposes.

For additional information on the Plan's credentialing process, please call the Provider Credentialing department at (502) 585-8315, or visit our web site, www.passporthealthplan.com/providercenter.

Questions

If you have questions regarding this communication, please contact your Provider Relations representative or the Provider Relations department at (502) 585-7943.

PASSPORT HEALTH PLAN
REGISTRATION OF LOCUM TENENS PHYSICIAN



The maximum time may not exceed sixty (60) continuous days.

I certify and attest, by my signature below, under penalty of perjury, that the information contained herein is true and faithful.

<p>This physician is the TEMPORARY REPLACEMENT who applies and will actually perform the services on a short term basis.</p> <hr/> <p>Applicant (Locum Tenens Provider) Full Name</p> <hr/> <p>Permanent Address 1 (May not use a PO Box)</p> <hr/> <p>Address 2</p> <hr/> <p>City, State, Zip</p> <hr/> <p>Social Security Number</p> <hr/> <p>NPI # Exp. date DEA # Exp. date</p> <hr/> <p>Kentucky Medical License Number</p>	<p>This physician will be ABSENT during the billing and will not perform the services.</p> <hr/> <p>Regular Physician Full Name</p> <hr/> <p>Office Address 1 (May not use a PO Box)</p> <hr/> <p>Address 2</p> <hr/> <p>City, State, Zip</p> <hr/> <p>Specific Duration – Not to exceed 60 consecutive days:</p> <p style="text-align: center;">_____ to _____</p> <p style="text-align: center;">MM/DD/YY MM/DD/YY</p> <hr/> <p>NPI # Exp. date DEA # Exp. date</p> <hr/> <p>Passport Health Plan Provider ID Number</p>	
<p>Is a CONTRACT AGENCY involved in this placement?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES – If yes, please supply name and address of agency:</p> <hr/> <p>Address 1</p> <hr/> <p>Address 2</p> <hr/> <p>City, State, Zip</p> <hr/> <p>To my knowledge, I attest that I am not subject to any of the following:</p> <ul style="list-style-type: none"> • A pending criminal or civil investigation regarding the provision of health care services; • Formal disciplinary sanctions from any board or professional association pursuant to KRS311.565; and/or • A federal or state sanction or penalty that would prevent me from participation in Medicare or Medicaid. <hr/> <p>Signature (locum tenens) Date</p>	<p>CHECK OFF REQUIRED ATTACHMENTS:</p> <p><input type="checkbox"/> Copy of valid physician license, DEA certificate, and a copy of any applicable board certification for the locum tenens physician</p> <p><input type="checkbox"/> PROOF of malpractice insurance coverage for the locum tenens physician for period of physician substitution</p> <p>The Q-6 Modifier must be used for billing services performed by a locum tenens physician.</p> <p>The holder of the valid provider number is required to bill the services of any locum tenens physician by utilizing the Health Care Procedure Coding System with the procedure modified code Q-6 in item 24d of form HCFA-1500 for every procedure performed by the locum tenens physician. Failure to bill correctly may be considered a violation of the terms of the Provider Agreement.</p> <hr/> <p>Signature (regular physician) Date</p>	
<p>RETURN THIS FORM TO:</p>		
<p>FAX: (502) 585-8280</p>	<p>MAIL: Passport Health Plan Attn: Contracting Department 305 West Broadway, 3rd Floor Louisville, KY 40202</p>	