

Provider Information Change Form

You have requested a change to your Passport Health Plan provider information. To verify the change, please complete the information below and send to:

FAX: (502) 585-6060 -OR- **MAIL:** Passport Health Plan
ATTN: Provider Relations
5100 Commerce Crossings Drive, Louisville, KY 40229

Plan ID #: _____ NPI: _____

Medicaid Individual #: _____ Group Medicaid ID #: _____

PRACTICE NAME	
OLD:	
NEW:	
TAX ID NUMBER	TELEPHONE NUMBER
OLD:	OLD:
NEW:	NEW:
FAX NUMBER	E-MAIL ADDRESS
OLD:	OLD:
NEW:	NEW:
REMIT ADDRESS	SITE ADDRESS
OLD:	OLD:
NEW:	NEW:
1099 / TAX ADDRESS (IF DIFFERENT FROM REMIT) <input type="checkbox"/> USE REMIT ADDRESS	
OLD:	
NEW:	

Effective Date of Change: _____

Signature of Person Providing Information

Telephone #

Date