

Provider Contract Request Form

Thank you for your interest in becoming a Passport Health Plan by Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to contracting@passporthealthplan.com or fax to (833) 529-1081.

If you are adding providers to a participating group or PHO/PO, please submit a Provider Information Update Form to contracting@passporthealthplan.com.

PLEASE SELECT PROVIDER TYPE					
☐ Individual	☐ Medical Group	□ ASC	☐ Urgent Care	□ FQHC	□ RHC
☐ Behavioral Health	 	D DME	Other		
		D Other			
LINE OF BUSINESS					
☐ Medicaid [D-SNP	☐ Marketplace			
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CONTACT INFORMATION					
Requestor Name:			Requestor Phone:		
Requestor Email:			Requestor Fax:		
PROVIDER INFORMATION					
Legal Entity Name:					
Business/Service Address:(If additional locations please attach roster)			Mailing address:(Contract will be emailed)		
City, State, Zip:			City, State, and Zip:		
Office Phone:			Contact Phone:		
Office Fax:			Contact Fax:		
Office Email:			Contact Email:		
PROVIDER IDENTIFICATION					
Group Specialty:			Tax ID (TIN):		
Group Billing NPI(s):					
			* List all Group NF	PI(s) applicable to the	corresponding Tax ID
** Kentucky Medicaid ID Number:(A Medicaid ID is required. If you do not have a group/individual Medicaid ID issued from DMS, we will not be able to proceed with a group/individual agreement.)					
Hospital Affiliation(s):					

Once the completed form is submitted, please allow 3-5 business days for a contract packet to be emailed to the contact email you provided above. The contract packet will allow you an opportunity to provide us with additional details about your practice/services to ensure proper contracting and enrollment setup. Application status requests can be emailed to contracting@passporthealthplan.com