PASSPORT BY MOLINA HEALTHCARE

# 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 |
|---|---|
| Terming 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<br>• W-9<br>• Sample Claim Form (de-identified) |
| Change or add a service location | • PIF – Complete Section A, Section G, Section O<br>- 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<br>• Sample Claim Form (de-identified)<br>• W-9 |
| Change TIN only | • PIF – Complete Section A, Section B, Section O<br>• W-9<br>• 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 |

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| Add or Change Taxonomy | • PIF – Complete Section A, Section N, Section O |

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| 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<br>- 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:<br>• Add new provider(s) to an existing group<br>• Add a new group NPI and Provider(s) to the existing Tax Identification Number (TIN)<br>* 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 |

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| 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 PIF, or to load a new Billing NPI when received with a PAF. |
| **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 …** |
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| 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.**<br><br>Also, please include the Disclosure of Ownership and Control Form and a W9.<br><br>These forms can be found on our website at www.passporthealthplan.com<br><br>Passport Health Plan by Molina Healthcare<br>Attention: Provider Contracts<br>5100 Commerce Crossings Drive<br>Louisville, KY 40229<br>Fax#: (833) 529-1081<br><br>Email: contracting@passporthealthplan.com |

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| **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. |

# 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.**

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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.

*Return to first page.*

## SECTION B

**Tax ID Number Change** Effective Date of Change_____ /_____ / _____

Previous Tax ID Number _____ New Tax ID Number _____

*Return to first page.*

## SECTION C

**Group/Provider NPI Change** Effective Date of Change_____ /_____ / _____

_____ Group _____ Individual

Group/Provider Name: _____

Previous NPI: _____ New NPI: _____

*Return to first page.*

## SECTION D

**Group/Practice Add or Change** Effective Date of Change_____ /_____ / _____

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

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

*Return to first page.*

## SECTION E

**Individual Name Change** Effective Date of Change_____ /_____ / _____

Previous Name: _____ New Name: _____

Provider NPI: _____

*Return to first page.*

## 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: _____ |

*Return to first page.*

## 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: _____

*Return to first page.*

## 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.*

*Return to first page.*

## SECTION J

**Terming a Provider**

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

Provider NPI: _____ Date of Termination: _____

Reason for Termination: _____

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

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

*Return to first page.*

## 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): _____

*Return to first page.*

## 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*): _____

*Return to first page.*

## 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: _____

*Return to first page.*

## 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: _____

*Return to first page.*

## SECTION O

**Requestor Contact information**

Requestor Contact Name: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Address: _____ City, State, Zip: _____

*Return to first page.*

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
5100 Commerce Crossings Drive
Louisville, KY 40229
Fax#: (833) 529-1081
contracting@passporthealthplan.com