PASSPORT HEALTH PLAN

PROVIDER TERMINATION REQUEST FORM

Please complete this form and return to Passport Health Plan via email to passport.credentialing@passporthealthplan.com or fax to (502) 585-7987.

Today's Date: _____

Check appropriate box:

❑ Specialist ❑ PCP (Note: PCP panel re-assignment instructions must be included, as indicated below.)

Provider's Name: _____

Provider Plan #: _____ Provider's Kentucky Medicaid #: _____

Provider's NPI#:_____ **Termination Date: _____

Group Name: _____

Group Plan #: _____Group NPI #:_____ Group Tax ID #: _____

The reason for termination, please check only one box:

❑ Resigned** ❑ Moved Out-of-State ❑ Deceased ❑ Retired

❑ Practice Closed ❑ Leave of Absence* ❑ Sabbatical*

❑ Provider Transferred to_____ (Group Name)

❑ Other _____ (Explain)

* In these instances, please provide a separate explanation of the details in the "Additional Information" section below for our Credentialing Department (i.e. duration of absence for leave or sabbatical.)

** Your Passport contract requires a 90 day written notifcation. **Therefore, in accordance with your contract, <u>your termination date with the plan will be 90 days from the receipt of this request</u>.** Meanwhile, your panel will be closed to new members.

PCP Panel Re-Assignment Instructions:

❑ Passport member re-assignment.

❑ Please re-assign member panel to:

PCP's Name: _____

NPI #: _____ PCP's Individual PHP#: _____

Additional Information:_____

_____

_____

Name of person completing form: (please print) _____

Signature: _____ Telephone Number: _____