Primary Care Provider Member Dismissal Form

INCOMPLETE FORMS WILL NOT BE PROCESSED.

Please complete one form per member. Dismissals will be made effective 30 days from the date of receipt. For more information regarding member dismissal policies please refer to the Provider Manual.
*denotes required fields

Provider Information

*Provider Name: _____

*Provider TIN: _____ *Provider NPI: _____

*Address: _____

*Contact Name: _____ *Contact Phone Number: (_____) _____ - _____

Member Information

*Member First Name: _____ *Member Last Name: _____

*Member ID: _____ *Member DOB: _____

*Dismissal Reason Please check one of the following, corresponding detail is required:

☐ Incompatibility of the PCP/patient relationship
*Detail: _____

☐ Inability to meet the medical needs of the member.
*Detail: _____

☐ Member has not utilized a service within one year of enrollment in the PCP's practice.
Please list the six (6) attempts to contact member below:

1. *Date: _____ Method: _____ 4. *Date: _____ Method: _____
2. *Date: _____ Method: _____ 5. *Date: _____ Method: _____
3. *Date: _____ Method: _____ 6. *Date: _____ Method: _____

☐ *Detail: _____

***Date dismissal notification letter was sent to member:** _____

*Signature: _____

Printed Name: _____ Date: _____

Please note the effective date will be 30 days after the date Passport Health Plan receives the dismissal form and NOT the signature date.

Internal Use ONLY: Rec'd Date Rec'd By

Please submit to Provider Relations at:

Fax: 502-585-6060
Email: ProviderRelations@passporthealthplan.com
Mail: Passport Health Plan by Molina Healthcare
Attn: Provider Relations
5100 Commerce Crossing Dr
Louisville, KY 40229

PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE