PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Provider Grievance Form

- All fields must be completed to successfully process your request.
- Please attach all pertinent documentation to this form.

Submission Methods:

- Fax: 1-866-315-2572
- Online Portal: www.Availity.com
- Email: MHK_Provider_GnA@molinahealthcare.com
- Mail: Passport Health Plan of Molina Healthcare
  Attention: Provider Grievances
  P.O. Box 36030
  Louisville, KY 40233

Provider Information

Provider/Group Name:

NPI:

Contact Information

Contact Person:

Contact Phone Number/Contact Email:

Member Information (If Applicable)

Member Name:

Member ID:

Grievance Information

The date you became aware of the issue generating the grievance:

Check all that apply:

☐ Marketing ☐ Credentialing ☐ Provider Representative ☐ Member Related
☐ Communications ☐ Excessive Contact Center Wait Time ☐ Other

Please provide a detailed description of the issue(s) related to your grievance as indicated above: