KY Medicaid Partner Portal Application – Medicaid ID Request

KY Department for Medicaid Services
Division of Program Integrity

How to use this form:
Complete the required information and e-mail the form to medicaidpartnerportal.info@ky.gov. Put "Medicaid ID Request" in the subject line of the e-mail.

I (Provider/Owner), _____, hereby authorize _____, (Recipient's Full Name), to receive a copy of the Kentucky Medicaid Provider Number associated with my Social Security Number or Federal Tax ID and NPI.

I (Provider/Owner), _____, understand and acknowledge that my Kentucky Medicaid Provider Number will be sent to the e-mail address listed on this form (Recipient e-mail Address). I understand I am legally responsible for my Kentucky Medicaid Provider Number.

Complete the side of the table that is applicable to your provider type.

Individual Provider (Complete this column if you are an individual provider type)	**Group or Entity** Provider (Complete this column you are a Group or Entity provider type)
Provider Name Printed:	Owner/Officer or Board Member Name Printed:
Individual Provider NPI:	Group NPI:
Social Security Number:	Group Federal Tax Identification Number:
Recipient e-mail Address:	Recipient e-mail Address:
Individual Provider Signature:	Group Owner/Officer or Board Member Signature:
Date Signed:	Date Signed: