



## PROVIDER TERMINATION FORM

Please select one of the following: Section A or Section B

Section A: Terminate Contract

*Note: Termination of Contract Effective 90 days from date of receipt.*

Provider Name: \_\_\_\_\_

Group Name (if applicable): \_\_\_\_\_

Tax ID #: \_\_\_\_\_

Provider ID: \_\_\_\_\_

NPI #: \_\_\_\_\_

Specialty: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Section B: Provider No longer Affiliated with the Group

Effective Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Tax ID #: \_\_\_\_\_ Group NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

You may use the comment box below for a detailed explanation:

In order to implement changes the provider or office manager must sign and date below.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Contact #: \_\_\_\_\_