Provider/Practice Termination Form

Complete and submit this form to terminate a provider and re-assign members or to close a practice or practice site. Use the *Provider/Practice Change Form* to submit a provider or practice change.

Check appropriate box: ☐ PCP **Note**: Include PCP Re-assignment Instructions (Section IV). ☐ Specialist

Section I. Person Completing this Form

Name *(Last, First, MI)*	Phone No.	Email Address

Signature	Date Signed (MM/DD/YYYY)
X	

Section II. Provider Information

Provider Name *(Last, First, MI)*	Provider NPI No.	
Group Practice Name	**Group NPI No.**	**Group Tax ID No.**

Section III. Reason for Termination. Check (✓) only one box.

Reason	Effective Date (MM/DD/YYYY)	Reason	Effective Date (MM/DD/YYYY)
☐ Deceased		☐ Leave of Absence**	
☐ Practice Closed*		☐ Resigned	
☐ Retired		☐ Provider Sanctioned**	
☐ Moved Out-of-State		☐ Sabbatical**	
☐ Transferred	**Group Name**		**Effective Date** (MM/DD/YYYY)
☐ Other – Please Explain	**Explanation**		**Effective Date** (MM/DD/YYYY)

**If different than Group Practice listed in Section II, give practice name, city and state in Section V.*
***Give detailed explanation (such as, duration of absence for leave/sabbatical or sanction specifics) in Section V.*

Section IV. PCP Re-Assignment Instructions

☐ Please reach out to members for re-assignment.
NOTE: Please attach a list of members' names and addresses on separate page in Excel format.

☐ Please re-assign member panel to PCP named below.

PCP Full Name		NPI No.		Individual PHP No.	

Section V. Additional Information

Mail | Fax | Email	Internal Use Only
QualChoice P.O. Box 25610 Little Rock, AR 72221 F: 501.707.6811 E: PR@QualChoice.com	☐ Date rec'd by PR_____ Initials _____ ☐ Credentialing required? ☐ Y ☐ N Initials _____ ☐ Date rec'd by Prov Data Team_____ Initials _____ ☐ Date QA completed_____ Initials _____