



**GROUP PROVIDER TERMINATION FORM**

DATE: \_\_\_\_\_

PRACTICE NAME: \_\_\_\_\_ TAX ID \_\_\_\_\_

**CONTACT INFORMATION OF PERSON SUBMITTING THIS FORM:**

CONTACT NAME / TITLE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City ST Zip

PHONE \_\_\_\_\_ FAX \_\_\_\_\_ EMAIL \_\_\_\_\_

**INFORMATION ABOUT PROVIDER BEING TERMINATED FROM THE GROUP PRACTICE:**

PROVIDER NAME: \_\_\_\_\_ NPI#: \_\_\_\_\_

SPECIALTY(IES) : \_\_\_\_\_ TERMINATION DATE: \_\_\_\_\_

REASON FOR LEAVING:  Moving out of Area  Inactive Leave  Deceased  
 Joined another Practice  Retiring  Other

PROVIDER NAME: \_\_\_\_\_ NPI#: \_\_\_\_\_

SPECIALTY(IES) : \_\_\_\_\_ TERMINATION DATE: \_\_\_\_\_

REASON FOR LEAVING:  Moving out of Area  Inactive Leave  Deceased  
 Joined another Practice  Retiring  Other

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SPECIALTY(IES) : \_\_\_\_\_ TERMINATION DATE: \_\_\_\_\_

REASON FOR LEAVING:  Moving out of Area  Inactive Leave  Deceased  
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**UPON COMPLETION, PLEASE FAX TO: 775-982-8003**