PROVIDER NOTIFICATION OF TERMINATION

PROVIDER TERMINATION (INDIVIDUAL)

Provider name:		Individual Provider NPI:	
Clinic name:			
Address provider is terminating from:			
City:		State:	County:
Zip code:	Phone:		Fax:
Clinic NPI:			
Tax ID:			
Effective date of termination:			

Is provider being affiliated to another service address? ☐ Yes ☐ No			
*If yes, please provide **additional service address** below*			
Clinic name:			
Clinic address:			
City:		State:	County:
Zip code:	Phone:		Fax:
NPI:			
Medicaid Site ID:			
Tax ID:			
Effective date:			

PROVIDER NOTIFICATION OF TERMINATION

CLINIC CLOSURE

Is this clinic closing? ☐ Yes ☐ No			
*If yes, please provide **service address of closing clinic** below*			
Clinic name:			
Clinic address:			
City:		State:	County:
Zip code:	Phone:		Fax:
NPI:			
Tax ID:			
Are providers affiliated with this clinic terminating as well? ☐ Yes ☐ No			
If yes, please attach a list of providers terming, their NPI, and the effective date			

Are providers affiliated with this clinic moving to a new clinic? ☐ Yes ☐ No			
If yes, please attach a list of provider names, their NPI, and the new clinic information			
Clinic name:			
Clinic address:			
City:		State:	County:
Zip code:	Phone:		Fax:
NPI:			
Tax ID:			