



# Provider Termination Request Form

Please complete this form and fax to Neighborhood Health Plan Provider Enrollment at 617-772-5517.

Today's Date: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Provider's NPI #: \_\_\_\_\_ Termination date: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice NPI #: \_\_\_\_\_ Practice Federal ID #: \_\_\_\_\_

**The reason for termination, please check only one box:**

- Resigned
- Retired
- Deceased
- Leave of Absence \_\_\_\_\_
- Provider Transferred to \_\_\_\_\_ (Practice Name)
- Other \_\_\_\_\_ (Explain)
- Moved out-of-state
- Practice Closed
- Provider Sanctioned
- Sabbatical \_\_\_\_\_ (How long?)

**Check appropriate box:**

- Specialist
- PCP (PCP Panel Re-assignment Instructions must be included below)

**PCP Panel Re-assignment Instructions:**

- I have re-assigned the PCP's members via NHPNet  
(Please re-assign members via NHPnet prior to, or within 3 business days, of submitting this form)

OR

- I do not have access to NHPnet, therefore please re-assign patient panel to:

PCP Provider's Name \_\_\_\_\_ NPI # \_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of person requesting termination: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ (if we should have any questions)