PROVIDER NETWORK TERMINATION FORM

Instructions: Please complete this form to notify Verda Health Plan of provider network terminations for participating PCPs or Specialists. All sections are required unless otherwise noted.
Please include a copy of the: 1) written provider notification, 2) list of assigned members, and 3) Continuity of Care Plan (CoC).

Date of Submission: _____
Name & e-mail of person submitting this form: _____

Applicable Line of Business: ☐ MAPD ☐ C-SNP

Provider Type: ☐ Specialist ☐ PCP

Section 1. Complete for All Providers:

Effective Date of Termination: _____

Provider Name: _____

Provider NPI: _____ Specialty: _____

Termination Reason: _____

Terming Provider TIN: _____

Terming Provider Primary Address: _____

Are any members in the middle of care (Yes/No) (if Yes please attach CoC): _____

Section 2. PCP Terminations Only:

Total # of membership for Terming PCP Provider: _____

Currently Assigned Member Name & ID: _____
(if more than one, please attach a separate sheet)

How many miles between Terming PCP to New PCP: _____

New PCP Name: _____

New PCP NPI: _____ Specialty: _____

New PCP TIN: _____

New PCP Primary Address: _____

New PCP Primary Address Ph #: _____ Fax # _____

Section 3. Comments/Special Instructions:

_____

_____

_____

For Verda Health Internal Use Only
Date document received from PS: _____
Date term letter processed and mailed to member(s): _____
Returned By and Title: _____

Submit this form and all supporting information to: providerservices@verdahealthcare.com