PROVIDER NETWORK TERMINATION FORM

Instructions: Please complete this form to notify Verda Health Plan of provider network terminations for participating PCPs and Specialists. All sections are required unless otherwise noted.

ALL NOTIFICATIONS MUST BE SUBMITTED 60 DAYS IN ADVANCE.

Name & E-mail of person submitting this form: ______________________________
Date of Submission to Verda Provider Services: ______________

Applicable Line of Business: ☐ MAPD ☐ C-SNP

Provider Type: ☐ Specialist ☐ PCP

Section 1. Complete for All Providers:

Termination Effective Date (**Must be 60 days in advance**): ______________________________

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 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 & PCP ID: ______________________________

New PCP NPI: ______________ Specialty: ______________________________

New PCP TIN: ______________________________

New PCP Primary Address: ______________________________

New PCP Primary Address Ph #: ____________________ Fax # ____________________

Section 4. Comments/Special Instructions:

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For Verda Health Internal Use Only

Date submitted to M.E.: ____________________
Date term letter processed and mailed to member(s): ____________________
Returned By and Title: ______________________________

Submit this form and all supporting information to: ProviderServices@VerdaHealthcare.com