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: _____ IPA Name: _____

Provider NPI: _____ Specialty (if PCP, please provide PCP ID): _____

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: _____ IPA Name: _____

New PCP NPI: _____ PCP ID: _____

New PCP TIN: _____

New PCP Primary Address: _____

New PCP Primary Address Phone#: _____ Fax # _____

The Member Effective Date with the new PCP: _____

Section 4. Comments/Special Instructions:

_____

_____

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