PROVIDER NETWORK –
PANEL CHANGE FORM

Instructions: Please complete this form to notify Verda Health Plan of Texas provider Panel Changes, 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:

☐ Close Panel (Note: Providers are responsible for continued treatment of existing members)

☐ Open Panel

Effective Date (**must be 60 days in advance for request to close panel**)_____

Provider Name:_____

Provider NPI:_____Specialty: _____

Reason for Panel Change: _____

Provider TIN:_____

Provider Primary Address: _____

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