Chronic Care Management Termination Form

As of _____/ _____/ _____, I have decided to terminate my participation in the UroPartners Chronic Care Management program.

I understand that any services provided in the future regarding any of my conditions will have to be in-person and that I will no longer be charged for the Chronic Care Management codes.

_____	_____
Patient Name	Date
_____	_____
Patient Signature	Date