

# Provider Request for Termination Form



Fax completed form to: 614-234-8673

Date: \_\_\_\_\_

Please complete applicable fields in all sections.

Office Practice Contact Person: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Email address: \_\_\_\_\_

Provider Name(s): \_\_\_\_\_ NPI# \_\_\_\_\_

*(Name all providers who are affected by the changes on this form)*

Group Practice Name: \_\_\_\_\_ NPI# \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_

Effective date with practice: \_\_\_\_\_

## Provider Termination Information

Provider Name: \_\_\_\_\_ Provider NPI# \_\_\_\_\_

Provider is terming from MediGold. Date of Termination: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_ Group NPI# \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider NPI# \_\_\_\_\_

Provider is terming from MediGold. Date of Termination: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_ Group NPI# \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider NPI# \_\_\_\_\_

Provider is terming from MediGold. Date of Termination: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_ Group NPI# \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider NPI# \_\_\_\_\_

Provider is terming from MediGold. Date of Termination: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_ Group NPI# \_\_\_\_\_