Neighborhood Health Plan OF RHODE ISLAND™

Attention: Provider Relations
910 Douglas Pike
Smithfield, RI 02917
Phone: 1-800-963-1001
Fax: 1-401-709-7066
Email: PECCredentialing@nhpri.org

Practitioner Termination Notification Form

Please complete this form and return to Provider Relations via the address information above.

Date: _____ **Number of pages (including this cover sheet):** _____

Provider Group Name: _____ **Site Liaison/Contact Name:** _____

Phone Number: _____ **Fax Number:** _____

A. Current Information

Practitioner Name:

Neighborhood ID #:

Termination Date:

B. Network Participation

Please indicate the practitioner's reason for leaving the provider group:

❑ Retirement ❑ Moved out of state ❑ Left the group" ❑ Other:

"Does the practitioner wish to remain in the network: ❑ Yes ❑ No ❑ Unknown

C. New Practice Information

Provider Group Name:

Phone Number: Fax Number:

Start Date: Contact Name:

D. Member Information

Does this practitioner currently have a panel of Neighborhood members assigned to him/her? ❑ Yes ❑ No

If so, to whom should the members be reassigned? Please list practitioner name(s) and specifications as necessary:

Name: Neighborhood Provider ID #:

Name: Neighborhood Provider ID #:

Notes:

D. Authorized Signature

The information on this form is accurate and may be processed accordingly.

Signature: Date: