Hometown Health   Senior Care Plus

PROVIDER TERMINATION FORM

Date ______________________

Practice Name ______________________ Tax ID ______________________

Group NPI ______________________

Contact/Title ______________________

Address ______________________

City ______________________ State ______________________ Zip ______________________

Phone ______________________ Fax ______________________ Email ______________________

INFORMATION ABOUT PROVIDER BEING TERMINATED FROM THE GROUP PRACTICE

Provider Name ______________________ NPI# ______________________

Specialty ______________________ Termination Date ______________________

Reason for Leaving

- ☐ Moving out of Area
- ☐ Inactive Leave
- ☐ Deceased
- ☐ Joined another Practice
- ☐ Retiring
- ☐ Other

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Specialty ______________________ Termination Date ______________________

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IF YOU HAVE ADDITIONAL ADDRESSES TO TERMINATE, PLEASE ATTACHED A ROSTER WITH THIS FORM.

Upon completion please email to **ProviderUpdates@HometownHealth.com** with a SUBJECT LINE INCLUDING THE GROUP NAME AND TIN

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