Termination form for clinic/group billing

Please complete all sections of the termination request form in its entirety, document cannot be saved. Approximate length of time to complete is 5 minutes. Forms submitted with incomplete and/or missing information will delay the processing of your request.

☐ **Terminating from the network**

☐ **Terminating from a location**

1. **Termination request form:**
   Participation in the **Arkansas Blue Cross and Blue Shield PPP network is required**. Termination from the PPP network will terminate all affiliated networks. Termination to a location if other locations are remaining active will not affect the provider's network status. Complete each section of the form with indication *Not Applicable (N/A)* where appropriate. Please include an explanation in the Comment Section describing the termination you are requesting.

   ☐ **Full network termination**

   ☐ **Terminating Medicare Advantage**

   ☐ **Terminating PPO**

   ☐ **Terminating from a location**

2. **Attach photocopies of the following:**
   ✔ List of all locations provider is terminating from

Any questions may be directed to dentalproviderrelations@usablelife.com. You will receive a letter confirming your effective date.

***This form is for providers that are currently credentialed with Arkansas Blue Cross and Blue Shield.**

Please complete this form to notify Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, or USAble Corporation that a practitioner is leaving a clinic.

If you have any questions regarding completion of this form, please contact Dental Provider Network at dentalproviderrealations@usablelife.com . If the practitioner is changing addresses or other data, he/she must also complete the *Dental Change of Data Request* form. If a practitioner is joining another clinic, he/she must complete an *Abbreviated Application*.

To Provider Network: Please be advised that the practitioner listed below has/will terminate his/her association with the following clinic/group and the clinic's/group's authorization to receive payment on behalf of the practitioner is terminated.

Practitioner information

Name of practitioner	Provider number of practitioner	Date of termination

Name of clinic/group	Provider number of clinic/group

Contact person	Phone

Will the Practitioner continue to practice in Arkansas?

☐ Yes ☐ No

Forwarding information of practitioner

Forwarding address	City	State	ZIP	Forwarding phone

Signature

Print name of individual practitioner

Signature

Date of signature

Return completed form to:
Arkansas Blue Cross and Blue Shield
ATTN: Dental Provider Network Operations
PO Box 1650
Little Rock AR 72203

or

Fax: 501-208-8302

Email: dentalproviderrealations@usablelife.com