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 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.**

Termination Form for Clinic/Group Billing

Arkansas Blue Cross and Blue Shield • Health Advantage • USAble Corporation

Please complete this form to notify Arkansas Blue Cross and Blue Shield, Health Advantage, 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 *Authorization for Clinic Billing* form.

Form can be faxed to 501-208-8302 or emailed to dentalproviderrealations@usablelife.com.
You can also mail the forms to: Dental Provider Network Operations PO Box 1650 Little Rock AR 72203.

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.

Name of Practitioner _____

Provider # 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 address and telephone number of Practitioner _____

_____

_____

_____

_____
Print Name of Individual Practitioner

Signature _____ Date _____
(Individual Practitioner- NO STAMPS OR DIGITAL SIGNATURES)