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.

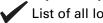
Full network termination

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		Return completed form to: Arkansas Blue Cross and Blue Shield ATTN: Dental Provider Network Operations PO Box 1650 Little Rock AR 72203 or									
						Date of signature		Fax: 501-208-8302			
								Email: dentalproviderrealations@usablelife.com			



