Arizona Priority Care (AZPC)

Provider Termination Form

Please complete the applicable information and email or fax to: Email: Provider.Network@AZPriorityCare.com
Fax: Attn: Provider Network (480) 499-8729

Current Information:	**Group Name**: _____ **Group Tax ID #:** _____ **Office Contact:** _____ **Office Email**: _____

Group Termination *(To be completed if the entire group contract is to be termed)*
Date of Term: _____ Reason for Term: _____

Individual Provider Terminations *(If you have more than 5 providers that you are terming and it is not a group term, please attach a page with the names and information requested below)*	
Provider #1 Term Request:	Provider Name & NPI: _____ Effective Date of Term: _____ Reason for Term: _____ Reassign Members (PCPs only)? ☐ Yes ☐ No If yes, provider to reassign to: _____ Forwarding Information: _____
Provider #2 Term Request:	Provider Name & NPI: _____ Effective Date of Term: _____ Reason for Term: _____ Reassign Members (PCPs only)? ☐ Yes ☐ No If yes, provider to reassign to: _____ Forwarding Information: _____
Provider #3 Term Request:	Provider Name & NPI: _____ Effective Date of Term: _____ Reason for Term: _____ Reassign Members (PCPs only)? ☐ Yes ☐ No If yes, provider to reassign to: _____ Forwarding Information: _____
Provider #4 Term Request:	Provider Name & NPI: _____ Effective Date of Term: _____ Reason for Term: _____ Reassign Members (PCPs only)? ☐ Yes ☐ No If yes, provider to reassign to: _____ Forwarding Information: _____
Provider #5 Term Request:	Provider Name & NPI: _____ Effective Date of Term: _____ Reason for Term: _____ Reassign Members (PCPs only)? ☐ Yes ☐ No If yes, provider to reassign to: _____ Forwarding Information: _____

Signature: _____ **Print Name/Title:** _____

Email Address: _____ **Date:** _____

If you have any questions, please email us at Provider.Network@AZPriorityCare.com