



Arizona Priority Care (AZPC)

Individual 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: _____
	Important: If this request is to terminate an entire practice or group, please complete the Group Termination request form : Group Termination Request form

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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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