



1380 Soldiers Field Road, Suite 300
Brighton, MA 02135
(Tel) 866-895-1786, (Fax) 866-614-1953

Provider Termination Request Form

Today's Date: ____ / ____ / ____

Type of Provider: PCP Specialist PCP/Specialist (dual)

Provider's Name: _____

Provider's NPI: _____ Requested Term Date: ____ / ____ / ____

Group Name: _____
(If possible, 60 days advance notice of termination)

Contracted Entity Name: _____

Group Address: _____

Group City, State, Zip: _____

Group Tax ID #: _____

Hat Code: _____

(Hat Code is a change between a PCP, Specialist, or PCP to Specialist designation)

The reason for termination, please check only one box:

- Deceased Retired Resigned Leave of Absence
- Moved out-of-state Transferred to: (Group name): _____
- Other: _____

PCMHI: Yes No

PCP Panel Re-Assignment Instructions:

If this is a PCP, is there another PCP at your office that you would like the patients re-assigned to?

No, Yes, PCP's Name: _____ PCP's NPI: _____

Print Name of Authorized person completing form

Signature of Authorized person completing form

Telephone Number:

Please Mail To: CeltiCare Health Plan of Massachusetts, Inc.™
1380 Soldiers Field Rd., Suite 300, Brighton, MA 02135
Or Fax To: Attention: Provider Relations at 617-787-1497