

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. Please fax the completed form to (501) 378-2465 or mail to:

Arkansas Blue Cross and Blue Shield
Attn: Provider Enrollment
PO Box 2181
Little Rock, AR 72203

If you have any questions regarding completion of this form, please contact Provider Enrollment at (501) 210-7050. If the practitioner is changing addresses or other data, he/she must also complete the *Application for Provider Number / Change of Data Request* form. If a practitioner is joining another clinic, he/she must complete an *Authorization for Clinic Billing* form.



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 (MM/DD/YYYY) _____

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 _____
(Clinic/Group Representative)

Date _____
(MM/DD/YYYY)