PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

PROVIDER CONTRACT TERMINATION

PHC Inventory#

Instructions: DHCS requires 60-day notice of all contract terminations. Please submit written notice of termination with this completed form as an attachment.

If PHC does not receive written notice, all terminations will be effective 60 days from the date the form is submitted.

Provider Type: ☐ **PCP** ☐ **Specialist** ☐ **Ancillary** ☐ **Facility**	**Specialty Type** (if applicable)**:**
Effective Date:	**Billing NPI#**
Practice/Facility Name as listed in the Provider Directory:	

Street:	City:	County:	Zip:

Reason for Termination:	☐ Retiring	☐ Moving out of Area
	☐ No Longer Accepting PHC Members	☐ Provider Deceased

Member Notification: Per DHCS, members must be notified in *writing* of any significant changes in the availability or location of covered services, or any significant change in information.

Were members notified of the change represented on this form? ☐ **YES** – Please attach a copy of the notification ☐ **NO**

Forwarding address for 1099 Tax Forms and Payments

☐ **Please send all outstanding payments and tax forms to the address below** ☐ **Please continue to use my Pay To Address on file**

Street:	City:	Suite#:	Zip:

Contact Information for Physical Location of Medical Records.

Location Name:			
Street:	City:	Suite#:	Zip:
Contact Name:	Phone:	Email:	

Instructions for Retrieving Medical Records for Members.

Information Verification

I attest that the information submitted in this application is correct and complete to the best of my knowledge and belief, and is furnished in good faith.

I am ☐ **The Provider** ☐ **An Authorized Agent of the Provider** ☐ **The PHC PR Representative for the Provider**

Name: _____ Date: _____

Signature: _____ Title: _____

Contact Email: _____ Phone: _____

Return this completed form (with written notification) to the Provider Relations Contract Unit by clicking the Submit Button or fax to 707-863-4599.

Submit

For Partnership Provider Relations Use Only

Provider PHC #(s) affected				
Term Form forwarded to QI for HEDIS				☐ **Yes** ☐ **No**
Number of beneficiaries assigned or affected by the termination of the provider if PCP:				
Number of provider sites within the appropriate time and distance standards for the county				
List of Sites Attached				☐ **Yes** ☐ **No** ☐ **NA**
Copy of Provider letter to Members attached (if available)?				☐ **Yes** ☐ **No**
Notification to RAC and Member Services				**Date:**