PROVIDER SITE CLOSURE FORM

Instructions:
Please complete the information below when closing one of multiple service locations. Do not use for contract terminations

Practice/Facility Name as listed in the Provider Directory:			
Street:	City:	County:	Zip:

Reason for Closure:	◯ Moving to a new location	◯ Closure due to business needs
	◯ Temporary closure for re-model	◯ Other:

If relocating, permanently or temporarily, please list the NEW address below

Street:	City:	County:	Zip:

Have you submitted formal written 60 day prior notification to the PHC PR Contracting Department? ◯ **Yes** ◯ **No**

Effective Date:	**Billing NPI#**

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(s) represented on this form?

◯ **YES** – Please attach a copy of the notification ◯ **NO**

Additional Notes:

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: _____

For Partnership Provider Relations Use Only

# of beneficiaries assigned or affected by the closure of the above clinic or PCP:			
# of provider sites within the county that members can be reassigned to.			
Provider PHC #(s) affected			

Return this completed form to the Provider Relations Contract Unit by fax to 707-639-5503. Attach a copy of your written notification to members. Or Click the Submit button to email this form and attachments.

Submit