PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

Attachment B – Letter 10a
Member Services Notifies PCP of Decision

<DATE>

FAX: **<Fax #>**
<Provider Office>
<Provider's Address>
<Provider's City, State and Zip>

Re: Request to discharge: **<mbr>** **PHC ID #**

Dear **<Name>**:

Partnership HealthPlan of California (PHC) has received your request to discharge the above member. The documentation submitted by your office has been reviewed by PHC. Based on the discharge guidelines outlined in PHC's Policy MP 316, your request has been:

☐ Approved. The member will be transferred from your practice, effective **<Date>**.

☐ Denied. It was determined that your request did not meet the discharge guidelines outlined in PHC's Policy MP 316. You must continue providing services to this member.

☐ Denied. It was determined that your request did not meet the discharge guidelines outlined in PHC's Policy MP 316. However, the member has requested to be transferred to another primary care provider. The effective date of the transfer is **<Date>**.

☐ Denied. Not enough information has been provided to approve your request. Please provide additional information that specifically details your reason for requesting the discharge and resubmit your disenrollment request. See enclosed Provider Discharge Tool to help determine the type of documentation needed. At this time, you must continue to provide services to this member.

☐ Other:

☐ Special message or instructions

If you have questions or concerns regarding this discharge request or if you would like to appeal this decision, please contact your Provider Relations Representative at **(707) 863-4100**.

Thank you for the excellent care you provide to our members and your continued support of PHC.

Sincerely,
Provider Relations Department
Partnership HealthPlan of California