



IHCP Provider Termination Request Form

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Billing Provider Termination Request

End date the following Billing Provider's Service Location or Locations.
 Terminate the following Billing Provider's IHCP Provider Agreement. I understand all of my provider service locations will be terminated with the termination effective date requested on this form for the submitted provider number.
 Is the provider a PMP? Yes No If yes, you must contact the Managed Care Entity first before terminating from the program or your assigned member panel will be lost and all members will be sent a letter telling them they need to choose a new PMP.

1. Requested Termination Effective Date:	2. IHCP Provider Number :	3. IHCP Service Location Alpha Suffix:
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4. National Provider Identifier:

5. Forwarding Address:

Terminate Rendering Provider Linkage from Group

Groups submit provider agreement termination requests for rendering providers associated with their group. All linkages to the group will be terminated with the requested termination date.
 Is the provider a PMP? Yes No If yes, you must contact the Managed Care Entity first before terminating the group linkage or your assigned member panel will be lost and all your members will be sent a letter telling them they need to choose a new PMP, which may not be from your group.

1. IHCP Provider Number:	2. LPI Alpha Location Suffix: (enter all locations to be terminated from)	3. NPI
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Rendering Provider Program Termination Request

Terminate the following Rendering Provider's IHCP Provider Agreement. I understand all of my provider linkages with the group identified on this form will be ended with the termination effective date requested on this form.
 Is the provider a PMP? Yes No If yes, you must contact the Managed Care Entity first before terminating from the program or your assigned member panel will be lost and all members will be sent a letter telling them they need to choose a new PMP.

1. Rendering IHCP Provider Number:	2. Rendering Provider National Provider Identifier:	3. Requested Termination Date:
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1. Rendering IHCP Provider Number:	2. Rendering Provider National Provider Identifier:	3. Requested Termination Date:
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1. Rendering IHCP Provider Number:	2. Rendering Provider National Provider Identifier:	3. Requested Termination Date:
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Authorized Signature Information

The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth herein. The undersigned acknowledges that the commission of any Medicaid or CHIP-related offense, as set out in 42 USC 1320a-7b may be punishable by a fine of up to \$25,000 or imprisonment of up to five years or both.

1. Authorized Official's Signature:	2. Title:
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3. Rendering Provider's Signature: (if available)	4. Date:
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