Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Provider Termination Form

Effective date may be impacted by contract terms and follow up may be required.

Group Name:	TIN:
Provider Name:	Provider NPI:
Termination Date:	

We cannot back date termination date

Reason for termination, please check only one box

- ☐ Resigned
- ☐ Retired
- ☐ Deceased
- ☐ Leave of absence*
- ☐ Moved out-of-state
- ☐ Practice closed
- ☐ Provider sanctioned*
- ☐ Sabbatical*
- ☐ Provider transferred to *(group name)*_____
- ☐ Other_____

***Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/why sanctioned/sabbatical specifics)**

Patient Panel
Who will take over patient panels:

Contact Person Submitting Information	
Name:	Title:
Phone:	
Email:	
Date of submission:	
Signature:	

Please send all Termination Requests to: ***ProviderChangeTerm@bidco.org***

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Provider Change Form

Group Name:	TIN:
Provider Name:	Provider NPI:

1. Type Of Change (Check all that apply)

☐ Name change (Please fill out part 3. Demographic change)	☐ Phone Number Change	Changing from: ☐HMFP to API ☐API to HMFP ☐ Other _____
☐ Address	☐ Status Change: PCP ☐ Status Change: SCP ☐ Status Change: PCP/SCP	☐ Panel change Open
☐ Tax ID*	☐ Adding a Practice Location	☐ Panel change Close
☐ Other		

***W9 required for billing changes**

2. Address Information:

New/Additional Address	Old Addresses
Address Type: ☐ Primary ☐Secondary ☐ Billing ☐ Mailing	Address Type: ☐ Primary ☐Secondary ☐ Billing ☐ Mailing
Address line1:	Address line1:
Address line 2:	Address line 2:
City:	City:
State: Zip:	State: Zip:
Phone:	Phone:

3. Demographic Change – 30 day notice required

Effective date:

☐ New provider name: Last Name:_____ First Name_____	☐ Old provider name: Last Name:_____ First Name:_____

4. Patient Panel:

☐ Panel Change Open_____ Close____ Effective Date_____

*Please be aware all panels will be open or closed with all contracted payers

5. Contact Person Submitting Information

Name:	Title:
Phone:	
Signature:	Date of submission:

Please send all Termination Requests to:* *ProviderChangeTerm@bidco.org