



WRITTEN NOTICE OF PROVIDER TERMINATION

PLEASE NOTIFY THE PROVIDER ENROLLMENT OFFICE WHEN AN INDIVIDUAL PROVIDER OR A GROUP TERMINATES.

- 1. Group Name: _____
 Grp. Prov. # _____ Term. Date: ____ / ____ / ____ NPI: _____
- 2. Ind. Prov. Name: _____
 Ind. Prov. # _____ Term. Date: ____ / ____ / ____ NPI: _____
- 3. Ind. Prov. Name: _____ Ind. Prov. # _____
 Grp. # _____ Term. Date: ____ / ____ / ____ NPI: _____
- 4. I.R.S Number: _____

IF THERE IS AN OWNERSHIP, NAME AND/OR IRS NUMBER CHANGE, PLEASE CONTACT THE PROVIDER ENROLLMENT OFFICE FOR A NEW APPLICATION PACKET.

**Physician's Signature or
Authorized Representative:** _____

Title: _____ **Telephone Number:** _____
Date: _____

Reason for the Termination request is best described by one or more of the following:

- Retired
- Moved out-of-state
- Poor Customer Service
- Difficulty with claims
- Deceased
- No longer participating
- Other:

Comments:

DO NOT ALTER THIS FORM IN ANY MANNER. SHOULD YOU HAVE QUESTIONS REGARDING THE COMPLETION OF THE FORM, PLEASE CALL 1-800-852-2683.

RETURN TO: PROVIDER REGISTRATION

**State of Tennessee
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243**