STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION DIVISION

DIVISION OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

WRITTEN NOTICE OF PROVIDER TERMINATION

Medicaid ID: _____ NPI (If applicable): _____

Termination Reason: Termination Date: _____

☐ **Retired**	☐ **Deceased**	**Moved out-of-state**	☐ **No longer participating**
☐ **Other**			

I understand that by signing below my Medicaid ID will be terminated. I also understand TennCare will notify all TennCare Managed Care Organizations including Dental Benefits Managers and Pharmacy Benefits Managers to terminate any contracts I may hold with them. TennCare nor any TennCare Managed Care Organization including Dental Benefits Managers and Pharmacy Benefits Managers will no longer recognize and adjudicate payments for any such service billed by me. Additionally, TennCare nor any TennCare Managed Care Organization including Dental Benefits Managers and Pharmacy Benefits Managers will no longer adjudicate payments for any such service and/or item ordered and/or referred by me for TennCare-eligible patients, specifically including prescriptions.

Signature: _____

Print Name: _____

Title: _____

Date: _____ Telephone Number: _____

Email Address: _____

Mailing address for any final correspondence:

_____

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Please contact the Provider Registration Call Center at: 1-800-852-2683 or email Provider.Registration@tn.gov for questions regarding this form.