Voluntary Termination Form

Please complete this form to request that your status as a participating provider within BCBSRI's network be terminated.

*Please note that Voluntary Termination **does not** apply to a change of practice location(s). If you are leaving one location, but will be practicing at another, please submit a* Practitioner Change Form *to provide information related to your practice change(s). To download or print a* Practitioner Change Form*, visit the provider section of bcbsri.com, click Forms, then Provider, then Provider Access/Administration.*

Date: ____/____/____

Provider name: ____

Group name (if applicable):____________________________________

Address: ____

City:______________________________ State: ______ ZIP: __________

Practice phone number: _______________

Practice contact person: ______________________________________

Practice e-mail address: ______________________________________

National Provider Identifier (NPI) Type 1 provider #: __________________

NPI Type 2 provider # (if applicable): ____________________________

Tax identification #: ____

Reason for termination: ☐ Retiring ☐ Leaving office ☐ Leaving state

☐ Other (please specify): ________________________

Effective date: ____/____/____

Important: If you are a primary care physician (PCP), please provide the name of ONE physician who will assume care of your patients.

Assuming physician's name: ___________________________________

Group name: ____

Signature of terminating provider: _________________________________

Please fax this form to (401) 459-2099, or scan and email it to ProvDB@bcbsri.org. If you have any questions regarding this form, please call the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.