Blue Cross Blue Shield of Rhode Island

Voluntary Termination Form

Please complete this form if you must terminate your status as a participating physician/provider. You are required by contract to submit this form 60 days in advance. Please note that it is not considered a termination if you are leaving one location and will remain a participating physician/provider at another location. In that case, please submit a Practitioner Change Form. If you have any questions or would like to obtain a Practitioner Change Form, please call the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050, or visit the Provider section of BCBSRI.com.

Date: _____ Physician/provider name: _____

Group name: _____ Practice phone number: _____

Practice contact person: _____ Practice contact e-mail address: _____

Address: _____

City: _____ State: _____ ZIP: _____

BlueCHiP Plan provider #: _____ BCBSRI Plan provider #: _____

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

NPI Type 2 provider # (if applicable): _____

Effective date of termination: _____

Reason for termination: ☐ Retiring ☐ Leaving Office. Reason: _____

☐ Other (please specify): _____

****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: _____

Your signature (terminating physician/provider): _____

Please fax this form to (401) 459-2099 or mail it to:

Attn: Contracting Technical Support – 00084
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, Rhode Island 02903-2699