Physician Termination

The information entered into this form is subject to review and approval by UPMC Health Plan. Submitting this information change form does not mean it is automatically uploaded to our system. Any questions resulting from our review must be addressed before the change is approved.

Date:* ____________________ Name of group or provider:* ____

☐ PCP ☐ Ob-gyn ☐ Specialist/Dental/Vision ☐ Ancillary (medical only) ☐ Chiropractor ☐ Extenders (CRNP, CNM, CRNA)

Contact name:* ___________________________________ Provider number: ___________________________

Phone:* __________________ Tax ID Number:* ________________ Email:* __________________________

Effective date:* ________________________ ** Required information*

Provider Type

☐ PCP

☐ Ob-gyn

☐ Specialist

☐ Extenders (CRNP, CNM, CRNA)

Reason for Termination

☐ Relocated within PA ☐ Deceased ☐ PHO resignation ☐ No longer has participating hospital privileges

☐ Relocated out-of-state ☐ Retired ☐ Voluntary resignation ☐ Other: __________________________________

Per the UPMC Health Plan Provider Agreement, providers must notify the Health Plan 90 days prior to date of termination.

For PCPs: Where are you referring your patients? ____

Return completed form by email, fax, or mail to:

UPMC Health Plan
Network Development & Provider Data Maintenance Dept.
U.S. Steel Tower - 14th Floor
600 Grant Street
Pittsburgh, PA 15219
Fax: 412-454-8225

providernetworkinquiries@upmc.edu
hpdental@upmc.edu (dental providers)
hpvision@upmc.edu (vision providers)

UPMC HEALTH PLAN

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PHYS TRMNTN FRM 17OP0763 (MCG) 7/12/17 PDF