Beth Israel Lahey Health
Performance Network

Provider Termination Form

Effective date may be impacted by contract terms and follow up may be required.

Group Name:	TIN:
Provider Name:	Provider NPI:
Termination Date:	

We cannot back date termination date

Reason for termination, please check only one box

☐ Resigned
☐ Retired
☐ Deceased
☐ Leave of absence*
☐ Moved out-of-state
☐ Practice closed
☐ Provider sanctioned*
☐ Sabbatical*
☐ Provider transferred to *(group name)*___________________
☐ Other____

***Please provide a separate explanation of the details to the plan (i.e., duration of absence for leave/why sanctioned/sabbatical specifics)**

Patient Panel
Who will take over patient panels:

Contact Person Submitting Information	
Name:	Title:
Phone:	
Email:	
Date of submission:	
Signature:	

Please send all Termination Requests to: WINHOSP_WinPHOEnrollmentTeam@lahey.org