WinchesterPHO

Physician Termination Form

Provider's Information:

Provider's Full Name:	Provider's Individual NPI:
Provider Type: ☐Primary Care Physician ☐ Specialist	If PCP, name of physician assuming your panel?
Practice Name:	TIN:
Phone:	Group NPI:
Email Address:	Term Effective Date:

Please note that we cannot back-date terminations.

Reason for Termination

- □ Resigned
- □ Provider Transferred to (group name)
- □ Retired
- □ Deceased
- □ Moved out of state
- □ Practice Closed
- □ Provider Sanctioned*
- □ Sabbatical*
- □ Leave of Absence*
- □ Other_____

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

Contact Person Submitting Information

Name/Title:	
Phone:	
Email:	
Date of submission:	
Signature:	

Return completed form by email, fax, or mail to:
lisa.m.enderle@lahey.org | 1021 Main St, Suite 201, Winchester, MA 01890 | FAX: 781-756-7274

Terminations are subject to the conditions of the Participation Agreement Section VIII – Term, Termination, and Default.