Termination Form



An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to notif	ly AZ Blue of a termination. Check the scenario that	at best o	describes the reason for t	he termination:	
☐ 1. Provider will n	o longer be practicing in Arizona (moving out of	Arizona	, retiring from practice, o	r is deceased)	
	e resigning from an AZ Blue provider contract (lue Shield® benefit plans, but will continue to prov				
☐ 3. Provider will be	e ending an affiliation with a tax ID (will remain i	n-netwo	ork and affiliated with othe	er tax IDs in Arizona)	
PROVIDER INFORMATION	Provider Last Name, First Name, MI, or Entity Name				
(Required)	Degree (if applicable) NPI Number				
	Tax ID Number				
CONTACT PERSON	Name and title of contact person preparing this form on behalf of a	a provider	Email	Phone	
EXPLANATION (Required: Complete section 1, 2, or 3 to explain the applicable scenario)	1. Explain why provider will no longer be practicing in Arizona (i.e., moving out of Arizona, retiring from practice, is deceased)				
	Note: When planning to relocate outside of the Arizona service area, please request a network participation contract from BCBS Plan covering the service area of your new location. For more information, visit the BCBS Companies and Licensees				
	Termination Effective Date (mm/dd/yyyy) / /				
2. Explain why provider will be resigning from an AZ Blue contract (will no longer be considered a Shield benefit plans, but will continue to provide out-of-network services in Arizona)				twork for Blue Cross Blue	
	Note: When a provider terminates a contract, we do not offer retroactive effective dates in the process of negotiating a new contract for network participation. We require a provider signature for resignations (may not be signed by anyone else).				
	Termination Effective Date (mm/dd/yyyy)				
	Note: Termination effective date must be in accordance with contractual agreement 3. Enter tax ID(s) to indicate which affiliation(s) the provider will be ending (but will be continuing with other tax IDs)				
	Tax ID: End Date:		g (but will be continuing with othe End Date:	er tax ids)	
		Tax ID:			
	Tax ID: End Date:	Tax ID:	End Date:		
	Tax ID: End Date: If provider is ending affiliations with more tax IDs, please attach	Tax ID:	End Date:		
	Provider is entiting affiliated with one or more tax IDs? Yes No.	If	no, complete #2 above to confirm om your AZ Blue contract.	your resignation	

Termination Form...continued



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ATTRIBUTED MEMBERS	Is the provider a PCP with attributed members for AZ Blue HMO plans? Y N I N I I yes, which provider(s) in the practice will be continuing care for the attributed members? Please attach list if necessary.			
SIGNATURE	Authorized Electronic Provider Signature			
(Required)	I am (name and title), and I verify that the information provided on this form is accurate. I agree that by entering my name in the electronic signature field below, I am verifying my intention to resign from my AZ Blue contract or terminate an affiliation with a tax ID.			
	Note: To resign from an AZ Blue contract, we require the legally authorized signature of the party named in the contract (individual provider, or for facilities/groups, a legally valid representative such as the owner, president, CEO, or Board Member).			
	/s/ /			

Sign, save, and attach the applicable documentation, and send to ProvNet@azblue.com or fax AZ Blue Provider Partnerships at 602-864-3142 • Questions? 602-864-4231