Blue Cross® Blue Shield® of Arizona
PROVIDER CONTRACT TERMINATION FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to notify AZ Blue of a provider contract termination. Check the scenario that best describes the reason for the termination:

- ☐ 1. Provider is **no longer practicing in Arizona** *(moved out of Arizona, retired from practice, or is deceased)*
- ☐ 2. Provider is **resigning from a BCBSAZ provider contract** *(will no longer be considered in-network for Blue Cross Blue Shield benefit plans but will continue to provide out-of-network services in Arizona)*
- ☐ 3. Provider is no longer practicing at your tax ID. Use the **CHANGE FORM** to add or remove a provider from a tax ID number (do not use this termination form).

Need to add or remove a provider from your tax ID number? Use the Provider Change Form.

PROVIDER INFORMATION *(Required)*	**Provider** Last Name, First Name, MI, or **Entity** Name	
	Degree *(if applicable)*	NPI Number
	Tax ID Number	
EXPLANATION *(Required: Complete section 1 or 2 to explain the applicable scenario)*	**1.** Explain why provider is **no longer practicing in Arizona** *(i.e., moved out of Arizona, retired from practice, is deceased)*	
	Effective Date *(mm/dd/yyyy)* / /	
	Name and title of authorized person preparing this form on behalf of a provider who is no longer practicing in Arizona	
	2. Explain why provider is **resigning from a BCBSAZ contract** *(will no longer be considered in-network for Blue Cross Blue Shield benefit plans, but will continue to provide out-of-network services in Arizona)*	
	Today's Date *(mm/dd/yyyy)* / /	
	Note: Termination effective date will be in accordance with contractual agreement	
ATTRIBUTED MEMBERS	Is the provider a PCP with attributed members for BCBSAZ HMO plans? ☐ Y ☐ N If yes, which provider(s) in the practice will be continuing care for the attributed members? Please attach list if necessary.	
SIGNATURE *(Required)*	**Authorized Electronic Provider Signature** ***(Required to resign from contract)***	
	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 BCBSAZ contract. /s/ _____ Authorized Electronic Provider Signature	_____/_____/_____ Date (MM/DD/YYYY)

Sign, save, and attach the applicable documentation, and SUBMIT BY EMAIL

or fax to BCBSAZ Provider Partnerships: 602-864-3142 • Questions? 602-864-4231