TERMINATION NOTICE

INSTRUCTIONS:
Please complete this termination notice if you wish to terminate your enrollment with Vermont Medicaid.
If you are a PCP, you need to notify Vermont Medicaid at least 90 days prior to the effective termination date.

NOTICE OF TERMINATION OF PARTICIPATION IN PC PLUS
All individually participating or group identified PCPs must notify HP, in writing, of their intention to withdraw from participation at least 90 days prior to the termination date. Closure of a practice due to the death of a PCP or sale of an individual practice, a group practice or a clinic will automatically terminate participation in the **PC *Plus*** plan.

If you are currently an active provider and you no longer wish to participate as a provider in the State of Vermont assisted health care programs, please indicate below. Your provider file will be closed on the date you specify, upon proof of 30 day notification to beneficiaries.

I no longer wish to be a Provider:

____________________________ CLOSURE DATE

____________________________ PROVIDER NUMBER

____________________________ SIGNATURE

____________________________ DATE

I am a PCP. YES ______ NO ______

Cancellation- This agreement may be cancelled by either the provider or the state in accordance with applicable state and federal laws and regulations.

This section is to be completed by a PCP provider. Please select one of the following two options:

☐ Transfer My Patients To: ____ (Provider Name)

☐ Move Patients Assigned To Me To: ____ (New Group Name)

New Address Information: ____________________________________

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New Contact Number: ______________________ New E-Mail Address: ____________________________________