DISENROLLMENT REQUEST FORM

Disenrollment Effective Date: _____

Disenrolling As:

- ☐ Individual
- ☐ Group
- ☐ Facility/Organization

Provider Information

Provider Name: _____

Individual Medicaid #: _____

Individual NPI #: _____

Group Medicaid #: _____

Group NPI #: _____

Facility/Organization Medicaid #: _____

Facility/Organization NPI #: _____

Disenrollment Reason:

- ☐ No longer Medicaid provider
- ☐ Moved out of city or state
- ☐ Physician died
- ☐ Retired
- ☐ Provider terminated
- ☐ Changing to private practice
- ☐ Other Please specify: _____

Patient 1st PMP patient reassignment (for Patient 1st providers only):

- ☐ Auto assign patients to other providers in the area.
- ☐ Auto assign patients to the following Patient 1st provider:

Name:_____

NPI/MCD_____

_____ _____

Provider or Authorized Representative's Signature Date

_____

Telephone Number

Please return this form by mail or fax to:

HP
Provider Enrollment
P O Box 241685
Montgomery, AL 36127
Fax Number: (334) 215-4298