Termination Form for Clinic/Group Billing

Arkansas Blue Cross and Blue Shield • Health Advantage • USAble Corporation

Please complete this form to notify Arkansas Blue Cross and Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas, or USAble Corporation that a practitioner is leaving a clinic.

If you have any questions regarding completion of this form, please contact Dental Provider Network at dentalproviderrealations@usablelife.com. If the practitioner is changing addresses or other data, he/she must also complete the *Dental Change of Data Request* form. If a practitioner is joining another clinic, he/she must complete an *Authorization for Clinic Billing* form.

Form can be faxed to 501-208-8302 or emailed to dentalproviderrealations@usablelife.com.
You can also mail the forms to: Dental Provider Network Operations PO Box 1650 Little Rock AR 72203.

To Provider Network:

Please be advised that the practitioner listed below has/will terminate his/her association with the following clinic/group and the clinic's/group's authorization to receive payment on behalf of the practitioner is terminated.

Name of Practitioner _____

Provider # of Practitioner _____

Date of Termination _____

Name of Clinic/Group _____

Provider Number of Clinic/Group _____

Contact Person _____ Phone # _____

Will the Practitioner continue to practice in Arkansas? Yes_____ No _____

Forwarding address and telephone number of Practitioner _____

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_____
Print Name of Individual Practitioner

Signature _____ Date _____
(Individual Practitioner- NO STAMPS OR DIGITAL SIGNATURES)