MARCH® Vision Care

Provider Termination Request Form

Please fax your completed form to (877) 627-2488 or email it to providerdemographics@marchvisioncare.com.

Tax Identification Number (TIN) requesting this termination:
Desired Effective Date of Termination*:

*If terminating all providers and all lines of business, the effective date must be 90 days from the date signed, per section 6.2.1 of the Provider Services Agreement.

Provider Information

Please terminate the following provider(s):*

Provider Name	National Provider ID (NPI)

*If additional space is needed, please attach a separate sheet, following the same format, and include your TIN on the top of the page.

Please select a reason for termination:

☐ Moved out of state ☐ Left practice/group ☐ Retired/deceased ☐ Sold practice

☐ Other (please explain): _____

_____

_____

_____

Signature Date

_____

Print Name Print Title

If you wish to add additional provider(s), please click here to complete a Provider Demographics Form. This form can also be found on our website at www.marchvisioncare.com, click on "Provider Resources", and select "Forms" from the left-side menu.