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 or 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 and title: _____

If you wish to add additional location(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.