UMPQUA HEALTH

UHA Contracted Provider Termination Form

Facility Name:	

PROVIDER TERMINATION: ☐	
Date Form Completed:	**Form Completed By:**

***For provider termination, please complete this section:**

Provider's First, Middle, Last**:**			
Termination End Date**:**		Date last seeing UHA Members**:**	
Reason for Termination:	☐ Relocated ☐ Retired		
	☐ Other- Explain**:**		
If a PCP, will members be automatically assigned to a different doctor within the clinic	☐ Yes ☐ No	If yes, please list PCP(s) who will take reassignment of members	

***For provider termination, please complete this section:**

Provider's First, Middle, Last**:**			
Termination End Date**:**		Date last seeing UHA Members**:**	
Reason for Termination:	☐ Relocated ☐ Retired		
	☐ Other- Explain**:**		
If a PCP, will members be automatically assigned to a different doctor within the clinic	☐ Yes ☐ No	If yes, please list PCP(s) who will take reassignment of members	

COMMENTS / NOTES:

Please email form to UHNProviderServices@UmpquaHealth.com
or fax to: (541) 229-4782

*****Clinic shall give UHN at least ninety (90) days' prior notice before any Clinic Provider retires from practice, or ceases Umpqua Health Network participation.**