Provider Termination Information Data Sheet

All fields with asterix are mandatory. Please complete this form in its entirety and use "N/A" if not applicable.*

Terming Provider Information		
*Group Name / Facility Name / Legal Name:	*Group tax ID	
*Last Name:	*First Name:	*Provider's NPI:
*Term Date:	*Term reason:	
* Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP	*Does this require a member move? ☐Yes. Please fill out Receiving Provider Information section below ☐No	
Receiving Provider Information		
*Last Name:	*First Name:	*Provider's NPI:
*Service location		
*Please attach any supporting documentation including terming provider approval if requesting for members to be moved to an alternative provider. (Per continuity of care, when a provider is terming with one group but holds an active contract with other groups under Molina, the members are to follow the PCP and continue their care. When requesting membership to be moved to a default provider with same IPA then an approval from the terming provider is required.)		