McLaren Medical Group

PATIENT TERMINATION REQUEST FORM

Patient Name: _____ Practice: _____

Date of Birth: _____ Insurance and ID#: _____

Patient Address: _____

TERMINATION FROM:

_____ Provider
_____ Practice
_____ Region
_____ Network

TERMINATION CATEGORY:

_____ No Show
_____ Breakdown in provider-patient relationship
_____ Non-Compliance Controlled Medicine Agreement
_____ Fraud (e.g., Prescription)
_____ Behavior
_____ Other, describe: _____

See Quick Reference Termination Guide for supporting documentation needed to process this request.

- □ Supporting documentation included
- □ Pt. demographics sheet or scanned insurance cards included

Please check box above when complete.

TERMINATION DESCRIPTION:

_____
_____
_____

Provider Name: _____ PCP Name, if specialist: _____
Provider Signature: _____ Date: _____
Manager Signature: _____ Date: _____

FOR INTERNAL USE ONLY

Date entered into Safety First: _____
Previous Dismissals: _____

Comments: ☐ Additional Documents Requested

_____
_____
_____
_____