

**McLaren Print System Order**

**Order No: 80353 Reprint Previous Order No: 5718**  
**Order Date: 2023-10-10**  
**User: TINA PLAUTZ**  
**Phone: 248-674-2259**

**Ship Location: Waterford Medical Associates**  
**5210 Highland Rd Ste 201**  
**Waterford, MI 48327**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 73000**  
**Dept Name: Waterford Medical Associates**  
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: MM-34586**  
**Item Description: PATIENT DISMISSAL REQUEST FORM**  
**Revision Date: 09/2023**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**



**PATIENT TERMINATION REQUEST FORM**

Patient Name: \_\_\_\_\_ Practice: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Insurance and CO: \_\_\_\_\_

Patient Address: \_\_\_\_\_

**TERMINATION FROM:**

- Provider
- Practice
- Region
- Network

**TERMINATION CATEGORY:**

- No Show
- Breach(es) in provider-patient relationship
- Non-compliance (Controlled Substance Agreement)
- Prescription Fraud
- Behavior
- Other, describe: \_\_\_\_\_

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

- Supporting documentation included
- PI, demographics sheet or scanned insurance cards included

Please check box above when complete.

**TERMINATION DESCRIPTION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Name: \_\_\_\_\_ ECP Name, if specialist: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR INTERNAL USE ONLY**

Date entered into Staffy First: \_\_\_\_\_

Previous Dismissal: \_\_\_\_\_

Comments:  Additional Documents Requested

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_