Medicare Advantage Non-Credentialed Practitioner Terminate Form

INSTRUCTIONS

- Terminate non-credentialed practitioners and specialists' records, such as anesthesiologists, audiologists, CRNAs, dietitians, ER physicians, occupational therapists, physical therapists, speech therapists, pathologists, and radiologists. Check with the facility if unsure if a practitioner is a non-credentialed type.
- Terminations are only required if the practitioner is deceased or retired.
- For status checks and questions on how to fill out the form, please contact Aspirus Health Plan's Provider Assistance Center at 715-631-7412 or toll free at 1-855-931-4851.

Email the completed form to demographicupdatesMA@aspirushealthplan.com.

ASPIRUS HEALTH PLAN

Non-Credentialed Practitioner Terminate Form

CONTACT INFORMATION

Completed and authorized on behalf of the practitioner by:

Name: **Title:**

Location Name:

Phone: **Fax:**

Email:

TERMINATE NON-CREDENTIALED PRACTITIONER DEMOGRAPHIC INFORMATION

Additional practitioners can be added on the last pages.

Last Name: **First Name:** **Middle Initial:**

Date of Birth: **Gender:** Female: Male:

Specialty:

NPI:

Moonlighting: **Hospitalist:** **Locum Tenon:**

DEA:

Title: MD: DO: DDS: DC: DPM: PhD: Other:

Practicing Specialty:

Taxonomy:

Degree:

License Number:

State: Wisconsin

Term Date (cannot be older than 18 months):

Term Reason:

Non-Credentialed Practitioner Terminate Form

OTHER INFORMATION:

Comments (Additional Information):

By signing this form below, you validate that the above information is accurate and true to the best of your knowledge.

Signature:

ASPIRUS HEALTH PLAN

Non-Credentialed Practitioner Terminate Form

ADDITIONAL PRACTITIONER #2

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Gender:** Female: ☐ Male: ☐

Specialty: _____

NPI: _____

Moonlighting: ☐ **Hospitalist:** ☐ **Locum Tenon:** ☐

DEA: _____

Title: MD: ☐ DO: ☐ DDS: ☐ DC: ☐ DPM: ☐ PhD: ☐ Other: _____

Practicing Specialty: _____

Taxonomy: _____

Degree: _____

License Number: _____

State: Wisconsin

Term Date (cannot be older than 18 months): _____

Term Reason:

_____

ASPIRUS HEALTH PLAN

Non-Credentialed Practitioner Terminate Form

ADDITIONAL PRACTITIONER #3

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Gender:** Female: ☐ Male: ☐

Specialty: _____

NPI: _____

Moonlighting: ☐ **Hospitalist:** ☐ **Locum Tenon:** ☐

DEA: _____

Title: MD: ☐ DO: ☐ DDS: ☐ DC: ☐ DPM: ☐ PhD: ☐ Other: _____

Practicing Specialty: _____

Taxonomy: _____

Degree: _____

License Number: _____

State: Wisconsin

Term Date (cannot be older than 18 months): _____

Term Reason:

_____

ASPIRUS HEALTH PLAN

Non-Credentialed Practitioner Terminate Form

ADDITIONAL PRACTITIONER #4

Last Name: **First Name:** **Middle Initial:**

Date of Birth: **Gender:** Female: Male:

Specialty:

NPI:

Moonlighting: **Hospitalist:** **Locum Tenon:**

DEA:

Title: MD: DO: DDS: DC: DPM: PhD: Other:

Practicing Specialty:

Taxonomy:

Degree:

License Number:

State: Wisconsin

Term Date (cannot be older than 18 months):

Term Reason:

ASPIRUS HEALTH PLAN

Non-Credentialed Practitioner Terminate Form

ADDITIONAL PRACTITIONER #5

Last Name: **First Name:** **Middle Initial:**

Date of Birth: **Gender:** Female: Male:

Specialty:

NPI:

Moonlighting: **Hospitalist:** **Locum Tenon:**

DEA:

Title: MD: DO: DDS: DC: DPM: PhD: Other:

Practicing Specialty:

Taxonomy:

Degree:

License Number:

State: Wisconsin

Term Date (cannot be older than 18 months):

Term Reason: