



TEACHERS HEALTH TRUST

Provider Add/Termination Form

ADDING

Provider(s) to a **Contracted Group**.

Name of Group: _____

Tax ID#: _____

Provider Name: _____

Start Date: ____/____/____

Specialty: _____

Provider Name: _____

Start Date: ____/____/____

Specialty: _____

Provider Name: _____

Start Date: ____/____/____

Specialty: _____

Please Note: Once Provider information is submitted to the Trust, credentialing documents must be completed *prior* to receiving claim payment(s). Therefore, the Trust recommends that all new Providers avoid seeing Trust Participants until credentialing is completed, and approved.

TERMINATING

Provider(s) to a **Contracted Group**. Please list Provider Name, Termination Date, and Reason for Termination.

Provider Name: _____

Termination Date: ____/____/____

- Moving out of State
- Inactive Leave
- Joined Another Practice
- Retiring
- Deceased
- Other _____

Provider Name: _____

Termination Date: ____/____/____

- Moving out of State
- Inactive Leave
- Joined Another Practice
- Retiring
- Deceased
- Other _____

Provider Name: _____

Termination Date: ____/____/____

- Moving out of State
- Inactive Leave
- Joined Another Practice
- Retiring
- Deceased
- Other _____

Please print legibly. To avoid delay in processing, please complete the required information below, (including Authorized Signature), and fax completed form to Teachers Health Trust at 702-866-6121.

Person Completing Form: _____

Title: _____

Phone: (____) _____ - _____ Extension: _____

Fax: (____) _____ - _____

Email Address: _____

Authorized Signature: _____

Date: ____/____/____