DirectNet
Healthy Together

PROVIDER TERMINATION FROM PARTICIPATING PRACTICE:

Please provide the following information:

1. Practice Name _____
2. Practice Tax ID # _____
3. Physical Address _____
4. Telephone # _____
5. Fax # _____
6. Terminated Provider Name _____
7. Terminated Provider NPI # _____
8. Effective date of Termination _____
9. Satellite Locations (if applicable)
   List below with address, telephone # and fax # for each location:

_____

_____

_____

_____

_____

_____

Please email the completed form to: lmorris@DirectNetLLC.com
OR
Fax to 828-485-4334