PROVIDER TERMINATION FROM PANEL REQUEST FORM

I, _____ in accordance with my Provider Participation Agreement (PPA) am requesting to be removed from the Envolve Vision provider panel.

- ☐ I understand that this request will be made effective based on the "Without Cause" timeline established in my PPA from date of receipt of this form.
- ☐ I understand that by submitting this termination request, I will be removed from all active contracts assigned to me for the Practice Tax ID indicated below.
- ☐ I understand that by submitting this termination request, if I wish to rejoin the provider panel I will be required to execute a new PPA and re-enter the initial credentialing process if no active credentialing exists.

Provider Name: _____

Provider NPI: _____

Tax ID Number: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Provider Signature: _____

Date Signed: _____

Please mail completed form to:

Envolve Vision, Inc.
Attn: Network Management
P.O. Box 7548
Rocky Mount, NC 27804

(Faxed or emailed forms will not be accepted)

For questions, please call Network Management at (800) 531-2818, option 4.