Medicare Advantage

Provider Notice to Discharge a Member from Panel

HealthSpring℠

Use this form to inform us if you discharge a member from your panel. Complete and submit it with supporting documentation to **your Provider Relations representative**.

Provider responsibilities: By submitting this form, you as the provider understand it is your responsibility to send the member a notice informing the member of your decision to terminate the provider and member relationship. You also understand you must give the member a minimum of 30 calendar days advance notice that the provider and member relationship will be ending. You are aware that you are required to continue member care for at least 30 to 45 days to allow the member time to select a new primary care provider. You will transfer, at no cost, a copy of the member medical records to the new PCP and will cooperate with the new PCP in regard to transitioning care and providing information about the member's care needs.

Provider name	POD
National Provider Identifier	Group name

The member referenced below is not following the accepted standards set by our office in order to maintain an effective treatment plan or a satisfactory provider and member relationship. The provider will send the member a provider and member relationship termination notice to advise the member to select a new PCP.

The notice will be sent on or before Date / /

Member name	ID	Health plan

The member displayed the following behavior

- ☐ Fraudulent use of services or benefits
- ☐ Threats of physical harm to a provider or the office staff
- ☐ Non-payment of required copayment for services rendered
- ☐ Receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or not medically necessary
- ☐ Refusal to accept a treatment or procedure recommended by the provider, if such refusal is incompatible with the continuation of the provider and member relationship. The provider should also indicate if he or she believes that no professionally acceptable alternative treatment or procedure exists.
- ☐ Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan
- ☐ Other behavior that has resulted in serious disruption of the provider and member relationship

Comments to substantiate the above behavior

Date(s) member was counseled/educated Date / /

Supporting documentation must be attached to substantiate that the member was counseled or educated on the issues described above. Documentation may include medical records, chart notes or incident reports, that document the member was called and reminded of the appointment; documentation of no shows; documentation of recommended treatment planor counseling.

Sign and date: The member has been counseled and educated and there has not been any improvement or progress. It is necessary for this member to be removed from my panel and to seek medical services elsewhere. I will continue to provide treatment for 30 to 45 days to allow the member time to select another PCP. By signing below, I agree to all statements in this notice and certify that my office follows all anti-discrimination policies.

Provider signature	Type or print name	Date / /