Provider Termination Request Form

The purpose of this form is to notify Superior Account Management that the following provider(s) is no longer contracted with Superior HealthPlan under your Taxpayer Identification Number (TIN). Please send the completed form to your local Account Manager to initiate the provider termination process.

PROVIDER INFORMATION

Person Completing the Form: _____ Email Address: _____

Phone Number: _____ Group Name: _____ Provider Name: _____

Taxpayer Identification Number (TIN): _____ National Provider Identifier (NPI): _____

Provider Termination Date: _____ Office Address: _____

TERMINATION REASON

Please select one of the following reasons for termination:

- ☐ Provider is retired
- ☐ Provider is no longer with this group
- ☐ Provider has moved out of state
- ☐ Other (Please explain): _____

For product-specific terminations (please select product(s) to be removed):

- ☐ STAR
- ☐ STAR Health
- ☐ STAR Kids
- ☐ STAR+PLUS
- ☐ CHIP
- ☐ STAR+PLUS MMP
- ☐ Ambetter from Superior HealthPlan
- ☐ Wellcare By Allwell (HMO)
- ☐ Wellcare By Allwell (HMO DSNP)

If the provider is a PCP, please indicate if a member move is needed and provide the new PCP information.

Member Move Needed: ◯ Yes ◯ No

Please provide the information for the member(s) new PCP:

Provider Name: _____ Provider TIN: _____ Provider NPI: _____

Please send the completed form to the Account Management Team in your Service Delivery Area (SDA).

Service Delivery Area (SDA)	Email Address
Bexar SDA	AM.SanAntonio@SuperiorHealthPlan.com
El Paso and West SDAs	AM.ElPaso@SuperiorHealthPlan.com
Travis and Central SDAs	AM.Austin@SuperiorHealthPlan.com
Hidalgo SDA	AM.Hidalgo@SuperiorHealthPlan.com
Dallas, Tarrant and Northeast SDAs	AM.Dallas@SuperiorHealthPlan.com
Lubbock SDA	AM.Lubbock@SuperiorHealthPlan.com
Nueces SDA	AM.CorpusChristi@SuperiorHealthPlan.com
Harris and Jefferson SDAs	AM.Houston@SuperiorHealthPlan.com

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