PEHP Provider Contract Termination Request Form

Use this form to formally request termination of your PEHP Provider Contract. Per Section 4.3 of the agreement, either party may terminate without cause with 30 days' advance written notice.

Submission Instructions
Submit this completed form via one of the following methods:

» **Email:** providersubmissions@pehp.org

» **Mail:** PEHP Provider Contracting, 560 E 200 S, Salt Lake City, UT 84102

» **Message Center:** Secure Message Center in the New Provider Portal

Note: The 30-day notice period begins on the date PEHP receives your completed termination request.

Required Information
To process your termination request, please complete all fields.

Section 1: Group Information		
Group Name:		
Tax ID Number:		
Practice Address(es)		
Street:		
City:	State:	Zip:

If practice has multiple addresses, please list additional locations on Page 3 of this form.

Section 2: Provider Details on Contract		
Please list practitioners included in this termination request. If the number of practitioners exceeds the space provided, please submit a supplemental list.		
#	Provider Name	NPI Number
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Contract Termination Request

Section 3: Termination Details

Requested Termination Date: (The date you wish the contract to end, must be at least 30 days after submission.)

_____

Reason for Termination:

- ☐ Practice is closing
- ☐ Providers will continue practicing as Out-of-Network
- ☐ Other: _____

Section 4: Certification & Signature

By typing my name below, I certify that:

- **»** I am authorized to submit this termination request on behalf of the provider group listed above.
- **»** All information provided is accurate and complete.
- **»** I understand that PEHP requires a minimum of 30 days' written notice for contract termination, starting from the date the request is received.
- **»** A current W-9 is included with this submission.

Typed Name & Title:

Submission date:

Your 30 day notice period starts when PEHP receives your termination request.

Additional Address *(if applicable)*		
Practice Address(es)		
Street:		
City:	State:	Zip:

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City:	State:	Zip:

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