Provider Voluntary Termination Notice

I am writing to notify the Division of Health Care Financing and Policy (DHCFP) and its Fiscal Agent that I wish to voluntarily terminate from the Nevada Medicaid and Nevada Check Up programs. I understand that the below mentioned individual or entity shall also be terminated from any Managed Care Organization(s) enrollment, and the terminated individual or entity shall serve a one-year sit-out period.

Upon receipt of this form, the Fiscal Agent will update my provider file and my enrollment will be terminated from both the Fee-for-Service and Managed Care Organization(s). I understand that all outstanding Nevada Medicaid and Nevada Check Up claims must be submitted within the appropriate billing time frames. The termination request must be in line with Nevada Medicaid Services Manual (MSM) Chapter 100, all inclusive.

Please email this form in its entirety with the email subject line "Voluntary Termination Request" to: nv.providerapps@gainwelltechnologies.com. NOTE: This form must be signed by an authorized individual on the enrollment record with the DHCFP. Digital signatures are not accepted.

PROVIDER INFORMATION	
National Provider Identifier (NPI):	
Provider Name:	
Business/Facility Address:	
Provider Type and Specialty:	
REASON FOR TERMINATION	**TERMINATION DATE**
☐ Closing location. (Please explain why in Additional Comments field below) ☐ Reimbursement rates ☐ Retirement ☐ No longer accepting Medicaid recipients ☐ Unresolved claims/billing issues ☐ Other (Please explain in the Additional Comments field below)	Termination Effective Date (Note: Backdated requests shall not exceed more than five business days from the submission date.): Would you like DHCFP to call you regarding your decision to terminate enrollment? ☐ No ☐ Yes Contact Name: Contact Phone Number: Contact Email:
ADDITIONAL COMMENTS	

☐ **Owner** ☐ **Managing Employee** ☐ **Administrator** ☐ **Authorized Personnel/Agent** ☐ **Provider**

Print Name: _____

Provider Signature: _____ **Date:** _____