Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

PROVIDER CHANGE FORM – REMOVAL OF SUPPLEMENTAL PRACTITIONER

This form should be submitted when the association between your organization and that of a licensed practitioner (MD, PA, FNP, LCSW, etc.) has ended. Upon submission of this form, our records will be updated so that the indicated practitioner is no longer linked with your organization.

Provider Name: _____ NPI: _____

Practitioner's Name: _____ NPI: _____

Email Address: _____ End Date: _____

(Required for credentialing related communication)

Please list the specialties of this clinician that will no longer be provided and/or cannot be provided by another clinician:

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for the denial or termination of participation as a provider.

_____ _____

Signature of Authorized Person Date

_____ _____

Printed Name Title

Submit the complete form by email to Credentialing@TrilliumNC.org