Panel Release Form

Email form to: panelrelease@prestigehealthchoice.com
Fax to: 1-888-608-2826
(Provider terminates individual from provider practice)

This form is not intended for primary care providers who are unable to contact members for initial office visits. Only one member or family should be used per form. Please fill out the form in its entirety.

Provider name: _____________________________ Provider ID#: ______________________________

Provider address: ____

Member/family name(s): Member/family ID number(s):

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Please check reason for release:

☐ Member is noncompliant with treatment plan (this does not include a member's initial visit).

☐ Member is noncompliant with office policies (attach policy and/or narrative of incident that occurred).

☐ Member moved outside of service area (attach supporting documentation).

☐ Abusive, disruptive, unruly, or uncooperative behavior, fraudulent use of member ID card, or falsification of prescriptions (attach narrative).

☐ Other — Describe situation/factors that influenced/caused the provider to terminate the member from his/her practice:

____

____

I affirm:

- Three attempts were made to salvage the physician-patient relationship and documented in the member's medical record (unless termination was due to violent behavior).
- The member received verbal or written notification of the termination of services, (please attach any supporting documentation).
- The physician assisted the member in locating a new provider, (may include referring member to plan for list of in-network providers).
- Determined the member is not currently under treatment for a critical illness or recent surgery and was safe to be discharged/ terminated from services.
- If applicable, the member was given 30 days of emergency services (i.e., referrals, services, or Rx).

I, _____________________________________, do hereby attest that this information is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Physician Signature: ____ Date:_______________

P2352_1712