Remove Practice Location Form

Complete this form when an individual provider is removing a practice location(s). If you are requesting termination from one or more of our networks, you must fully complete the Request for Termination form.

GENERAL INFORMATION		
Individual Provider Last Name	First Name	Middle Initial

Individual Provider NPI	Languages Spoken
Group/Clinic Name	Group/Clinic NPI
Group/Clinic Tax ID Number	Effective Date
What is your specialty?	Are you a primary care provider (PCP)? ☐ Yes ☐ No

LOCATION TO BE REMOVED			
Physical Address			
City	State	Zip Code	Effective Date

LOCATION TO BE REMOVED			
Physical Address			
City	State	Zip Code	Effective Date

LOCATION TO BE REMOVED			
Physical Address			
City	State	Zip Code	Effective Date

CHECKLIST

Before returning this form to Blue Cross, please ensure the following:

- ☐ This form is fully completed, including the effective date of removal(s)
- ☐ This form is signed and dated

SUBMISSION INFORMATION (form completed by)	
Signature of Authorized Representative	Date
Contact Email Address	Contact Phone Number

Return Form To:

Email: network.administration@bcbsla.com
Mail: BCBSLA – Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

Fax: (225) 297-2750
Phone: 1-800-716-2299, option 3

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