



## DENTAL PROVIDER TERMINATION NOTICE

Clinic Name: \_\_\_\_\_

Dentist Name: \_\_\_\_\_  
Last First

Provider TIN #: \_\_\_\_\_ - \_\_\_\_\_ NPI: \_\_\_\_\_

### LOCATION

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Effective Date of Termination \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Reason for Termination:

No longer at this location       Retired       License Canceled       Sold practice

Office Contact Name: \_\_\_\_\_ Tel # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please fax the completed form to:  
Dental Services – Provider Relations  
Fax Number - (208) 286-3575

Or mail completed form to:  
Blue Cross of Idaho – Dental Services  
PO Box 7408  
Boise, ID 83707