Voluntary Termination Notification Instructions

Getting Started

Providers may request termination from the VBA Network with sixty (60)-days advance notice by completing this Voluntary Termination Notification. Terminations take effect at the end of the 60th day following receipt of this Notification. Processing may be delayed if the form is not completed accurately.

For additional information including responsibilities, requirements and continuation of care, see the VBA Participating Provider Agreement and the VBA Professional Provider Manual.

Completing the Form

Complete the form electronically or print to complete by hand. Termination Type, Contact Info and Signature sections should be completed for all Voluntary Termination Types.

Notification requires the Signature Information box to be filled out completely upon return.

Voluntary Termination Types:

- **Practice Termination:** Terminates all Billing Accounts, participating Locations and enrolled Providers associated with the Practice (Tax ID). If the Practice is closing or has been sold, a final mailing address should be notated for final payment and 1099 documents. One Tax ID per Notification.
- **Location Termination**: Terminates a single participating Location and enrolled Providers at the terminating location only. One Location Termination per Notification.
- **Provider Termination:** Terminates a single provider from the Practice (Tax ID) or up to three participating Locations. One Provider per Notification. If the request exceeds the space provided on the form, complete an additional form, or, alternatively, submit by attaching a separate spreadsheet.

Select one Voluntary Termination Type on the form below.

How to Submit

After completing and signing the Voluntary Termination Notification, you may email, fax or mail to:

Email: providers@vbaplans.com

Fax: 412-885-5646

Mail: VBA, 400 Lydia Street, Suite 300, Carnegie, PA 15106

Next Steps

Please allow up to seven (7) business days for VBA to review your Notification and confirm receipt. If you submit incomplete documentation, a delay in processing may occur.

The VBA Provider Relations team will confirm receipt of your form by email and again after the termination process is complete. If your account closes in a negative balance, the balance will be due immediately upon termination.

Voluntary Termination Notification

This form is required to terminate a Practice, Location or Provider from the VBA Provider Network. Select one Voluntary Termination Type.

Termination Type		
☐	Practice Termination	Complete Contact Info, Practice Termination and Signature sections.
☐	Location Termination	Complete Contact Info, Location Termination and Signature sections.
☐	Provider Termination	Complete Contact Infor, Provider Termination and Signature sections.

Provide contact information for the person who can answer questions about this Notification at your office.

Contact Info		
Today's Date:		Phone Number:
Office Contact Name:		Email:

Complete this box to terminate Billing Accounts, Locations and Providers associated with the Practice Tax ID.

Practice Termination			
Practice Payee Name:			Effective Date:
☐ Term all accounts and providers associated with Tax ID			Tax ID:
Final Mailing Address:			
City:	State:		Zip:
Phone:	Fax:		
Reason for Termination			
☐ Closed Practice	☐ Reimbursement Rates		☐ Unsatisfied with Lab Choices
☐ Sold Practice	☐ No longer accepting routine vision insurance		☐ Other:

Complete this section to terminate one Location and the enrolled Providers.

Location Termination		
VBA Provider #:		☐ Term this location and all associated Providers
Address:		Effective Date:
Reason for Termination		
☐ Closed Location	☐ Sold Location	☐ Location no longer providing routine vision

Complete this section to terminate one Provider.

Provider Termination	
Provider Name:	Provider NPI:
☐ Term Provider from all locations associated with Tax ID (Complete Name, NPI, and Tax ID only for this section)	Tax ID:
☐ Term Provider from these locations only	
VBA Provider #	Effective Date:
Location Address:	
VBA Provider #	Effective Date:
Location Address:	
VBA Provider #	Effective Date:
Location Address:	

Signature	
By signing this form, I certify that I have the authority to terminate the Practice, Location, or Provider.	
Signature:	
Print Name:	Date: