



Georgia Medicaid Provider ID or Payee ID Termination Request Form

Doc Type	4119
1. Medicaid or Payee ID Number*	

ONLY ONE Medicaid or Payee ID per form.

Purpose of this form:

This form can be used to Terminate (Discontinue Participation) ONE Georgia Medicaid Rendering Provider ID or ONE Georgia Medicaid Payee ID.

Termination Request Form Instructions:

- In the box at the top right-hand corner of the form under the Doc Type number (4119), print the Medicaid Provider ID or Payee ID, whichever is applicable for the Termination requested. Only enter ONE Medicaid or Payee ID per form. If you have multiple Medicaid IDs (i.e., 99999A, 99999B, etc.), a separate Form will be required for EACH ID. The Provider or Payee name entered in Step 2 below must match the record for the ID entered in the box above.
- Enter the Rendering Provider **OR** Payee's information along with the Requested Effective Date of the Termination.
 - ONLY if the Termination is for a Rendering Provider (Individual or Facility), Enter the Provider's Name in this field.
 - ONLY if the Termination requested is for a Payee ID, Enter the Payee Name in this field. This is not required if the Provider's name is entered in field "a".
 - NPI is ONLY required for Termination requests for a Rendering Provider ID. If information is not entered in field "a", NPI is not required.
 - Tax ID is required for ALL termination requests.
- Complete the contact information for the individual and/or organization making this request.
- By signing this form, you are attesting that you are authorized to submit this request on the Provider or Payee's behalf. Forms that are not signed or incomplete will not be processed.

****Termination Requests for Contracts (440, 680, 681) need to be submitted DIRECTLY to DBHDD and Contract (590) terminations need to be submitted to (DHS) Department of Aging Services, not HP Provider Enrollment.****

MAIL the completed form to:

**HP Enterprise Services
Attn: Provider Enrollment Unit
P.O. Box 105201
Tucker, GA. 30085-5201**

FAX the completed form to:

1-866-483-1044

OR

To insure this document is routed correctly, fax each request separately and please, DO NOT INCLUDE A COVER SHEET.

2. Provider or Payee ID Information		Requested Effective Date of Termination:*	
a. Provider's Name:*		c. NPI:*	
b. Payee Name:		d. Tax ID:*	
3. Contact Information-Person Requesting the Termination*			
Name of Person Submitting Request:*			
Facility/Organization/Practice Name:			
Mailing Address:*			
Suite #: (if Applicable):	City: *	St:*	Zip:*
Contact Phone #:*		Contact Fax #:	
Contact E-Mail Address:			
4. Certification and Signature*			
Printed Name of Authorized Individual:*			Title:*
Signature of Authorized Individual:*			Date:*

All fields marked with "*" are REQUIRED.