SELECT HEALTH NETWORK

PROVIDER TERMINATION NOTIFICATION FORM

Select Use Only:
Notification Date: _____

Effective Date of Termination:_____

Please Print

Provider Information

Practitioner Name	
Tax ID	
Practice Name	
Practice Address	
City, State, Zip	
Phone Number	
Practice Manager	
Practice Manager e-mail address	

Termination Details

(Please note – The below section ***MUST*** be completed in its entirety
before Select Health Network is able to consider your membership fee refund request)

Leaving the Select Health Network Service Area (St. Joseph, Marshall or Elkhart Counties)	❑ Yes (Provide the details of your future office location) Address: City: State: Zip Code: ❑ No ❑ Unknown
Retiring	❑
Death	❑

Completion of this form is required to ensure accurate claim processing
Return completed form to Select Health Network, Provider Relations, at (574) 283-5950

314 W. Catalpa Dr., Ste. A • Mishawaka, IN 46545
Phone: (574) 283-5959 • Fax: (574) 283-5950