



Aspirus Network, Inc. (ANI) Practice Demographic or Location Close/Term Form

If your practice is closing/terminating any practice demographic structure or location (i.e., a Tax-id, NPI, address, legal name or dba name, ownership, etc.), please complete this Practice Demographic or Location Close/Term Form in its entirety and submit to ANI's Customer Service at Customerservice-ANI@aspirus.org.

This Form should be submitted to ANI ninety (90) days *in advance* of the requested effective date of the change.

Aspirus Network, Inc. (ANI)
Practice Demographic or Location Close/Term Form

Please complete the Form below:

All fields are required. If it does not apply, please enter N/A. Attach any supporting documentation.

| ANI Member |
|--|
| Member Organization: <input type="checkbox"/> CIN Member <input type="checkbox"/> Affiliate Member |
| Type of Close/Term: <input type="checkbox"/> Tax ID Number <input type="checkbox"/> Legal Name and/or DBA <input type="checkbox"/> Ownership <input type="checkbox"/> NPI <input type="checkbox"/> Address |
| Will the Close/Term Impact: <input type="checkbox"/> Inpatient/Outpatient <input type="checkbox"/> ASC <input type="checkbox"/> Clinic Non-RHC <input type="checkbox"/> Clinic RHC <input type="checkbox"/> SNF <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> FQHC <input type="checkbox"/> Psych Inpatient/Outpatient <input type="checkbox"/> Comprehensive Inpatient / Outpatient Rehab / BH Mental Health Treatment Program <input type="checkbox"/> Non-Licensed or Non- Credentialed Facility |
| Close/Term Reason: <input type="checkbox"/> Provider retiring <input type="checkbox"/> Financial <input type="checkbox"/> Merging with Another Entity <input type="checkbox"/> Acquisition <input type="checkbox"/> Relocation <input type="checkbox"/> Other _____ |
| Provide any additional information: |
| Effective Date of Close/Term: |
| DO NOT PROCEED UNTIL THE ABOVE IS COMPLETE |

Member Organization to Complete

Facility, Clinic, or Practice Demographic Structure to be Closed/Termed

| | |
|-------------------|-------------------|
| Legal Name: | Legal Name: |
| DBA Name: | DBA Name: |
| Tax ID Number: | Tax ID Number: |
| Location NPI: | Location NPI: |
| Group Medicare #: | Group Medicare #: |
| Group Medicaid #: | Group Medicaid #: |
| Phone Number: | Phone Number: |
| Fax Number: | Fax Number: |
| Physical Address: | Physical Address: |
| Physical City: | Physical City: |
| Physical State: | Physical State: |
| Physical Zip: | Physical Zip: |

MEMBER ORGANIZATION CONTACT PERSON

| |
|---|
| Organization Practice Administrator/Contact: |
| Organization Practice Administrator/Contact Email: |
| Organization Practice Administrator/Contact Phone: |

By signing this form below, you certify that the above information is accurate and true to the best of your knowledge.

Signature (type full name): _____ Date: _____

****Please Submit this Form to: CustomerService-ANI@aspirus.org**

****ANI will review and forward to ANI Credentialing and Provider Enrollment Upon Approval**

ANI Initials: _____ Date: _____