PCP DISMISSAL FORM

Member Name	Member's CCA ID Number	Member's DOB

Reason for Dismissal:

☐Member is abusive to provider or staff

☐Member fails to follow medical advice

☐Member fraud

☐Member fails to keep appointments (List dates) _____

☐Other (Please describe) _____

Explanation: _____

_____

_____

Full list of current medications:

_____

_____

_____

_____

Provider Signature _____ Date _____

FAX COMPLETED FORM TO 1-513-530-1378

This form is intended solely for PCP requesting "Termination of a Member" (refer to CCA Provider Manual). Complete this request in its entirety. Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the member until such time that written notification is received from CommuniCare stating, "The member has been transferred from the provider's practice." Providers are not allowed to communicate directly with plan members regarding intent to transfer a member from their panel. After receiving adequate documentation and making an administrative ruling, the plan will contact members regarding any changes in PCP assignments.