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PROVIDER DEACTIVATION OR SPECIALTY REMOVAL FORM

Complete this form to deactivate a Provider's association to an Agency or a District, or to remove a specialty or specialties from an existing Provider set-up.

Deactivate Provider

Complete this section to deactivate a provider's association to an Agency or District. Complete a separate form for each provider type.

❑ **Agency Provider** ❑ **Independent Provider** ❑ **District Employee**

Agency Name (if applicable) _____

Provider First Name_____ MI_____ Last Name_____

Provider Deactivation Effective Date_____

District Information

- If you are an Agency provider, please skip this section – District enrollment is dictated by the Agency.
- If you are an Independent provider, please select all of the Districts in which you are requesting to be deactivated.
- If you are a District Employee, please **indicate only one District per form;** if provider deactivation is required for multiple Districts then a separate deactivation request form is required per District.

❑ 1-1 Rome (Northwest Health District)
❑ 1-2 Dalton (North Georgia Health District)
❑ 2 Gainesville (North Health District)
❑ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
❑ 3-2 Fulton (Fulton Health District)
❑ 3-3 Clayton (Clayton County Health District)
❑ 3-4 East Metro (East Metro Health District)
❑ 3-5 DeKalb (DeKalb Health District)
❑ 4 LaGrange (LaGrange Health District)
❑ 5-1 Dublin (South Central Health District)
❑ 5-2 Macon (North Central Health District)
❑ 6 Augusta (East Central Health District)
❑ 7 Columbus (West Central Health District)
❑ 8-1 Valdosta (South Health District)
❑ 8-2 Albany (Southwest Health District)
❑ 9-1 Coastal (Coastal Health District)
❑ 9-2 Waycross (Southeast Health District)
❑ 10 Athens (Northeast Health District)

Remove Specialty

Complete this section when removing existing provider specialty information. Complete a separate form for each provider

❑ **Agency Provider** ❑ **Independent Provider** ❑ **District Employee**

Agency Name (if applicable) _____

Early Intervention Specialty

Please indicate all specialties which apply and the effective end date of the specialty.

Deactivate	Specialty	Effective End Date
❑	Assistive Technology Provider	/ /
❑	Audiologist	/ /
❑	Counseling – Licensed Professional	/ /
❑	Dietitian	/ /
❑	Early Intervention Assistant	/ /

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❑	Early Intervention Specialist	/ /
❑	Early Interventionist	/ /
❑	Family Member	/ /
❑	Intake Coordinator	/ /
❑	Interpreters for the Deaf	/ /
❑	Nurse – Registered (RN)	/ /
❑	Nurse- Licensed Nurse Practitioner (LNP)	/ /
❑	Nurse- Licensed Practical (LPN)	/ /
❑	Occupational Therapist	/ /
❑	Ophthalmologist	/ /
❑	Optometrist	/ /
❑	Parent Educator	/ /
❑	Physical Therapist	/ /
❑	Physician	/ /
❑	Physician Assistant	/ /
❑	Psychologist - Licensed	/ /
❑	Service Coordinator	/ /
❑	SLPA (Speech Language Pathologist Assistant)- Clinical Fellow	/ /
❑	Social Worker - Licensed Clinical	/ /
❑	Speech Pathologist	/ /
❑	Translator: Non-Spanish Foreign Language	/ /
❑	Translator: Spanish Language	/ /
❑	Transportation Company	/ /
❑	Vision Teacher	/ /

Requests to remove a provider specialty require a District signature from each District in which the provider is enrolled.

District Signature _____ Date _____

District Contact Name (please print)_____ Phone # ( )_____

District Signature _____ Date _____

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District Contact Name (please print)_____ Phone # ( )_____

District Signature _____ Date _____

District Contact Name (please print)_____ Phone # ( )_____

District Signature _____ Date _____

District Contact Name (please print)_____ Phone # ( )_____

District Signature _____ Date _____

District Contact Name (please print)_____ Phone # ( )_____

Please complete this Deactivation/Removal Form and mail the original to:

Central Finance Office
Attn: Provider Enrollment, CSC
P.O. Box 29370
Shawnee Mission, KS 66201-9370
Phone: 855-708-6612
Fax: 913-888-6683