Form 022015ACP

Removing an Affiliate or Partner Provider to an ACP Network

Provider Name:	
Provider Tax Identification Number (TIN):	
Partner or Affiliate?	
Termination Date: (ACP Network assigns anticipated termination date)	
Was the Provider in more than one Network?	
Approximate Number of Health Care Providers: Approximate Number of PCPs: Approximate Number of Specialists: Name(s) of Hospitals:	
Name(s) of Service Area Counties Covered:	

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