PROVIDER TERMINATION FROM PARTICIPATING PRACTICE:

Please provide the following information:

1. Practice Name _____
2. Physical Address _____
3. Telephone # _____
4. Fax # _____
5. Terminated Provider Name _____
6. Effective date of Termination _____
7. Satellite Locations (if applicable)

   List below with address, telephone # and fax # for each location:

_____

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Upon completion of the above information, please PRINT and mail to:
DirectNet
1333 2nd St., NE-Suite 200
Hickory, NC 28601

Or Fax to:
DirectNet
(828) 485-4334