An Independent Licensee of the Blue Cross and Blue Shield Association

CLOSED LOCATION FORM

To close a practice location or to close all locations.

FOR HMSA USE ONLY

NOTE: *According to your participating provider agreement with HMSA, if you're closing all of your practice locations, you'll need to give HMSA at least 60 calendar days' written notice to ensure proper continuity of care for your patients.*

If you're closing a practice location because you're moving to a new location in Hawaii, please use the Address Change Form.

REQUIRED INFORMATION

Provider Name: ____________________ Social Security Number (last four digits only): __________

National Provider Identifier (NPI) Number: ____________________ HMSA Provider ID Number: ____________________
(Indicate your *individual* NPI, **not** your clinic's or group's NPI.)

❑ COMPLETE CLOSURE OF ALL LOCATIONS (Complete this section if you're closing all locations because you're retiring, leaving the state, etc.)

Reason for Closure: ____________________ **Last Date You'll See Patients** ____________________

❑ I NO LONGER PRACTICE AT THE FOLLOWING LOCATION(S) If this is a Group Contracted location, please have the group submit the closure request:

Street Address of Closed Location: ____________________

Location Provider Number: ____________________ **Last Date You'll See Patients:** ____________________

Reason for Closure: ____________________

Street Address of Closed Location: ____________________

Location Provider Number: ____________________ **Last Date You'll See Patients:** ____________________

Reason for Closure: ____________________

Street Address of Closed Location: ____________________

Location Provider Number: ____________________ **Last Date You'll See Patients:** ____________________

Reason for Closure: ____________________

If you're closing additional locations, please attach a copy of this page.

MAILING ADDRESS (Please complete if applicable. **If you're closing all of your locations, please leave a forwarding address here**.)

Address: ____________________ ***Effective Date**: ____________________

City: ____________________ State: __________ ZIP: ____________________

* A future effective date (MM/DD/YY) is required to complete this request.

PROVIDER SIGNATURE (signature & date is required to process request)

If I have signed this Closed Location Form electronically, it means I acknowledge and agree to the terms of this Closed Location Form and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document [- in other words, typing my name as an electronic signature indicates I acknowledge and agree to the terms of this form just as a handwritten signature would on a traditional paper form].

Signature Date

SEND COMPLETED FORMS TO:

Mail
Provider Data Administration, Room 509
HMSA
P.O. Box 860
Honolulu, HI 96808-0860

Email provider_data@hmsa.com
Fax 948-8210 on Oahu
Phone 952-7847 on Oahu or 1 (800) 603-4672 X7847 toll-free on the Neighbor Islands