

Clinic/Branch Closure Form



Complete this form when closing a clinic or branch location

To allow proper transition of care for impacted members, provide at least a 60-day notice of a planned closure

Clinic Info:

Clinic Name:

NPI: Or UMPI#:

Tax ID:

Person completing the form:

Name:

Phone:

Email:

Clinic Location:

Street:

City:

State:

Zip Code:

Closure Info:

Effective Date of Closure:

Reason for closure:

Additional Clinic Closure(s):

Clinic Name:

Street:

City:

State:

Zip Code: Effective Date of Closure:

NPI: Or UMPI#:

Clinic Name:

Street:

City:

State:

Zip Code: Effective Date of Closure:

NPI: Or UMPI#:

Additional Clinic Closure(s):

Clinic Name:

Street:

City:

State:

Zip Code Effective Date of Closure:

NPI: Or UMPI#:

Clinic Name:

Street:

City:

State:

Zip Code Effective Date of Closure:

NPI: Or UMPI#:

Note: Submit as many Clinic/Branch Closure Forms as necessary, per 5 locations.

Complete and save this form, then email to

provider.data@bluecrossmn.com

Or mail to:

Provider Data Operations

PO BOX 982809

EL PASO TX 79998-2809

If you have any questions, contact Provider Service at (651) 662-5200 or 1-800-262-0820