ProviderConnect Online Services Account Deactivation Request Form

Provider, Practice or Facility Name

Beacon Health Options Assigned ID

National Provider Identifier (NPI)

Provider, Practice or Facility Tax ID (do not include the dash)

Address

City

State

Zip Code

(_____)
Telephone Number

(_____)
Fax Number

ProviderConnect Submitter ID / Login ID(s)

Contact's e-mail address

Contact Name (ProviderConnect Account User)

Agreement Terms:

The undersigned submitter authorizes Beacon Health Options, Inc. (Beacon) E-Support Services to de-activate any online accounts associated with their provider name and / or group practice. Any request for re-activation or future changes will require appropriate forms and signatures for processing.

This is to certify that the following is true:

☐ I am a provider

OR

☐ I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

Legal name of Organization

Title of individual signing for organization

Name of Individual Signing for Organization

Authorizing Signature

Date

Please return this form via fax to 866.698.6032

Beacon Health Options, Inc. | EDI Helpdesk | PO Box 1287, Latham, NY 12110 | Phone#: 888.247.9311

Incomplete, incorrect or illegible forms may delay or prevent proper processing