Physician Request for Removal of Member From Panel

Texas Children's® Health Plan

The member referenced below is not following the accepted standards set by our office in order to maintain an effective treatment plan or satisfactory patient/physician relationship. The information below is provided so that we can notify the member of such termination request, advising him/her to select a new primary care physician.

Member name: _____

Member number: _____

This member has displayed the following:

- ☐ Fraudulent use of services or benefits.
- ☐ Threats of physical harm to a provider or his/her office staff.
- ☐ Non-payment of required copayment for services rendered.
- ☐ Receipt of prescription medications or health services in a quantity or manner, which is not medically beneficial or medically necessary.
- ☐ Refusal to accept a treatment or procedure recommended by the provider, is such refusal is incompatible with the continuation of the patient-physician relationship. The provider should also indicate if he or she believes that no professionally acceptable alternative treatment or procedure exists.
- ☐ Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- ☐ Other behavior which has resulted in serious disruption of the patient-physician relationship.

Comments to substantiate the above: _____

_____

Date(s) member was counseled/educated: _____

Supporting documentation must be attached to substantiate that the member was counseled/educated on the importance of being compliant. (i.e.: Medical records, chart notes, incident report, that document the member was called and reminded of the appointment, documentation of no-shows; documentation of recommended treatment plan, counseled, etc.)

The above member has been counseled and educated and there has not been any improvement or progress. It is necessary for this member to be removed from my panel and to seek medical service elsewhere. I will continue to provide treatment for 30 days from the date the primary HMO notifies member that selection of another primary care physician is expected.

Signature of requesting primary care physician: _____ Date: _____

Type or print name: _____

Please fax request and supporting details/documentation to Texas Children's Health Plan Provider and Care Coordination at 832-825-8750.