Updated Physician Initiated Member Termination (PIMTR) Form

We've updated our form for a physician-initiated termination of a HAP Commercial or Medicare Advantage member from a practice. The form contains the acceptable reasons for transferring a member and the process for submission.

The form is attached for your convenience. You can always find the form and policy when you log in at **hap.org** and select *Policies and procedures* under *Resources*, *Working with HAP*.

If you are transferring your Medicaid or MI Health Link patient, you must complete the HAP CareSource form. Please visit **hapcaresource.com** and select *Provider*, then *Forms*.

Physician Initiated Member Transfer Request (PIMTR) Form

Important!

1. Use this form to transfer your HAP Commercial or HAP Medicare Advantage patient for reasons in section 2.
2. **If you are transferring your Medicaid or MI Health Link patient, you must complete the HAP CareSource form. Please visit hapcaresource.com; select *Provider*, then *Forms*.**
3. Patient should **not** be discharged from the practice without health plan approval (except pediatric discharge).
4. If you are part of a physician organization/physician hospital organization, do not send this form directly to HAP. The PO/PHO group medical director or their designee must complete this form.

SECTION 1: MEMBER INFORMATION		
Member Name:		
Member ID #:		
Member plan: ☐ HAP Commercial ☐ HAP Medicare Advantage		

SECTION 2: REASON FOR TRANSFER/DISCHARGE FROM PRACTICE

☐ Breakdown in the patient/physician relationship – due to one of the following:

- Verbal abuse or harassment
- Physical abuse or threatened physical abuse (provider contacted police for this behavior)
- Theft, dishonesty (provider contacted police for this behavior)
- Doctor shopping for the purpose of abusing prescription medications
- Fraud
- Non-payment of a member's account balance beyond 90 days which may include charges for applicable co-payments or services beyond the member's covered benefits, at an amount greater than $100
- Member refusal to engage in preventive services despite provider outreach efforts

☐ Repeated no-shows without appropriate cancelation/notification (if rules are posted in the office)

☐ Pediatric – reached age maximum for practice

Note: **Supporting documentation is required for any reason above (except pediatric discharge).** Member may continue treatment with this PCP if in an active course of treatment for an acute episode of chronic illness or acute medical condition, receiving care for a terminal illness, or in the second or third trimester of pregnancy.

SECTION 3: TO BE COMPLETED BY PRIMARY CARE PHYSICIAN OR PO/PHO		
Primary Care Physician:		NPI:
PO/PHO Name:		
Office Street Address:		
City/State/Zip:		
Phone:	Fax:	Email:
If applicable, transfer member to the following physician:		
Provider Name:		NPI:

SECTION 4 – SIGNATURE

I understand that I will continue to provide care for this member pending the final decision from HAP or HAP CareSource of this transfer request and until any such transfer is effective.

Signature of Primary Care Physician **Date**

NETWORK/GROUP MEDICAL DIRECTOR OR DESIGNEE APPROVAL

Signature of Network/Group Medical Director or Designee **Date**

Please email completed form and supporting documentation to providernetwork@hap.org or your HAP Provider Services Administrator. Put PIMTR in the subject line. Incomplete forms will be returned.

TO BE COMPLETED BY HEALTH PLAN

Date Received in Provider Services **Signature of Provider Services Administrator**