Subscriber Termination/PCP Change Form

(For Terminated Subscribers and PCP Changes Only)

Anthem.

Return To: Anthem Blue Cross and Blue Shield
P.O. Box 37910
Louisville, KY 40233-7910

Fax To: **(317) 488-6992**

From:

Group no.: _____

Group name: _____

Address: _____

City, state, ZIP: _____

Phone no.: _____

Date: _____

Termination ONLY				PCP Change ONLY			
Employee last name	**First**	**Employee ID no.**	**Last day worked**	**Member name**	**Effective date**	**New PCP name**	**New PCP no.**

For approved circumstances, Anthem's guidelines permit terminating a member 60 days retroactive.
***Pay-as-billed Process** – All adjustments will be applied to the next billing period. Please do not write changes, terminations, etc. on your premium billing statement.*

I hereby certify that the above information is complete and correct. By signing this form, if not the Employer, I represent that I have the authority to sign.

Signature of officer of employer, employer's authorized signer or broker/agent	Date

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