Sharp Health Plan Member Dismissal Request Form

This form is to be used by a Plan Provider's office to request dismissal of a current Member assigned under a Sharp Health Plan policy. Please include all supporting details and documentation for dismissal along with this request form and send by fax, or mail, to:

FAX:
Provider Relations
(858)408-9444

MAIL:
Sharp Health Plan
Attn: Provider Relations
8520 Tech Way, Suite 200
San Diego, CA 92123

PROVIDER INFORMATION

Provider Name			
Medical Group Name			
Telephone #		Fax #	
Signature			
Print Name			
Print Role/Title			
Dismissing from entire group? (Y/N)			

MEMBER INFORMATION

Member Name	
ID Number	
Date of Birth (MMDDYYYY)	

REASON FOR DISMISSAL

- ☐ Irreparable damage to the physician-patient relationship
- ☐ Financial
- ☐ Fraud
- ☐ Non-compliant
- ☐ Abusive or threatening
- ☐ Other (specify below)

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******************** **For Sharp Health Plan ONLY** ********************

Date dismissal request received	
Date all supporting documentation received	
Date review completed by Sharp Health Plan CMO	
Date Sharp Health Plan decision sent back to PCP	

If Dismissal is authorized

Member must elect new PCP by this date	
Date forwarded to Customer Care Department	