SHARP Health Plan

Member dismissal request form

Purpose

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.

Instructions

Please include all supporting details and documentation for dismissal along with this request form. Please refer to the Provider Operations Manual (POM) for additional information regarding the memberdismissal process. For questions, please contact the Provider Account Management team at provider.relations@sharp.com or 1-858-499-8330.

Submit

By Email:
Attention: Provider Account Management
provider.relations@sharp.com

By Fax:
Attention: Provider Account Management
1-858-303-9049

Provider Information		
Provider name:	Medical Group name:	
Telephone #:	Fax #:	
Provider signature:	Date (MM/DD/YYYY):	Dismissing from entire group? ☐ Yes ☐ No
Name of person completing form:	Role / title:	
Member Information		
Name:	ID number:	Date of birth (MM/DD/YYYY):
Reason for Dismissal		
☐ Financial ☐ Fraud ☐ Abusive or threatening ☐ Other (specify) _____		

Sharp Health Plan Use Only	
Date dismissal request received:	Date all supporting documentation received:
Date review completed by Sharp Health Plan CMO:	Date Sharp Health Plan decision sent to requesting provider:
If Dismissal is Authorized	
Member must elect new PCP by this date:	Date Sharp Health Plan decision sent to requesting provider: