# Restricted Recipient Program (RRP)
# Provider Initiated Change Request Form

Please complete this form:

1- If you no longer wish to be the provider of a member restricted to you OR
2- If you no longer wish to participate as a provider in the Restricted Recipient Program.

*Please provide notice at least 30 days prior to discontinuing your service. Per your contract, you are responsible for assisting in coordinating the member's continuation of care. Changes will be reflected in your panel report.*

**Request Date: ___ / _____ / ______**

***Please select ONE of the following:***

□ Opt Out of Being Provider For RRP Member:

**Member Name** ____________________

**DOB** ____________________

**Plan ID/CIN Number** ____________________

**Reason For Request:** ____________________

______________________________________

□ Opt Out From RR Provider Program:

*List All Members Currently Restricted to you:*

*Please use separate sheet for additional members if necessary.*

| Member Name | DOB | Plan ID/CIN Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***Please complete the following:***

| **Provider name:** | **Group Name:** |
|---|---|
| **Provider Type/Specialty:** | **Provider ID:** |
| **Site Address:** | |

**Requestor:** ____________________ **Title:** ____________________

**Signature:** ____________________ **Phone Number:** ____________________

**Print Name:** ____________________ **Date:** ____________________

***Please fax this completed form to the RRP Fax Line #646-738-8610.***