**Purpose**

Please use this form to request voluntary disenrollment from the Alameda County BHCS Mental Health Plan Provider Network.

**Instructions**

1. Complete the gray areas of the form
2. Sign and date
3. Fax to 510.567.8290 or mail this completed form to:

BHCS

c/o Provider Network Support

1900 Embarcadero Cove, Suite 205

Oakland, CA 94606

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I, |  | | | |  | | | request |
| *Provider/Practitioner Name* | | | | *Discipline/License Type* | | |
| disenrollment from the Mental Health Plan Specialty Mental Health Services Agreement | | | | | | | | |
| effective |  | | | | | | | |
| *Date* | | | | | | | |
| As set forth in my Specialty Mental Health Services Agreement, I understand that contractual obligations require: *“Records shall be retained by Contractor, and shall be made available for auditing and inspection, for no less than five (5) years following the provision of any services pursuant to this Agreement, or for a longer period as required by the applicable funding source.”* | | | | | | | | |
| In the future, BHCS, beneficiaries and/or their representatives may access medical records by contacting: | | | | | | | | |
|  | | |  | | | |  | |
| *Name* | | | *Address* | | | | *Phone* | |
| I certify that as a provider/practitioner under contract with BHCS I have documented discharge plans and coordinated continued medical care for all beneficiaries at the time of this disenrollment request. | | | | | | | | |
| Signature | |  | | Date | |  | | |