Employee & Family Resources, Inc.

Provider Inactivation Form

Date submitted: _____

Practice name: _____

Location of practice: _____

Clinician(s) to inactivate: _____

_____

_____

Inactivation date: _____

Reason for change: _____

Closed practice
No longer at practice
Retirement
Deceased
Other _____

Temporary inactivation: _____

Reason for leave (optional): _____

Inactivation date: _____

Return date: _____

Additional Comments: _____

_____

_____

Mail, fax, or email this request to:
Provider Relations
Employee & Family Resources
505 Fifth Avenue, Suite 600
Des Moines, IA 50309
Fax (515) 284-5201
ProviderRelations2@efr.org