PATIENT ACCEPTANCE FORM

This form should be completed and returned to Dean Health Plan if you are no longer accepting new patients. In the event you expect to discontinue taking new patients for an extended period of time, our member materials will be updated to reflect your status.

TODAY'S DATE: _____

NAME OF PRACTITIONER: _____

CLINIC NAME: _____

ADDRESS: _____

REASON FOR CLOSING PANEL/PROBLEMS EXPERIENCED: _____

_____

_____

_____

PRACTICE RESTRICTIONS: _____

SPECIALTY: _____

PANEL CLOSING FOR (please circle): COMMERICAL MEMBERS
MEDICAID MEMBERS
BOTH

EFFECTIVE DATE: _____

EXPIRATION DATE: _____

Please forward the completed form to your Provider Network Consultant at:

Dean Health Plan
Provider Services Department
PO Box 56099
Madison, WI 53705
Fax: 608-827-4300