



Online Provider Services  
Account Deactivation Request Form

Required fields are marked with an asterisk. \*  
Fax completed form to **866-698-6032**.  
Questions on this form? Call 888-247-9311.

\*Provider, Practice or Facility Name

**ValueOptions assigned Provider ID.** If not known, please contact the correct provider contacts on page 3

**\*NATIONAL PROVIDER IDENTIFIER # (NPI)**

\*Provider, Practice or Facility Tax ID (do not include the dash)

\*Address

\*City \_\_\_\_\_ \*State \_\_\_\_\_ \*Zip Code \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
\*Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

ProviderConnect Submitter ID/Login ID(s) if known: \_\_\_\_\_

\_\_\_\_\_ @ \_\_\_\_\_  
\* Provider's Contact e-mail address – Please print

\*Contact Name at Provider's Office

Agreement Terms:

The undersigned authorizes ValueOptions E-Support Services to de-activate any online accounts associated with their provider name and/or group practice. Any request for re-activation or future changes will require appropriate forms and signatures for processing.

\*This is to certify that the following is true:

\_\_\_ I am a provider  
OR  
\_\_\_ I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

\_\_\_\_\_  
Legal name of Organization \_\_\_\_\_ Title of individual signing for organization

\_\_\_\_\_  
\*Name of Individual Signing for Organization \*Authorizing Signature \*Date

For Internal Use Only: Initial \_\_\_ Date: \_\_\_\_\_