Palliative Care Program Patient Disenrollment Form

To ensure we have an accurate list of members enrolled in the Palliative Care Program, please use this form to notify Blue Shield Promise within 15 business days of a member's disenrollment from the Program.

Member Information:

Member name:
Member ID:
Member date of birth:
Disenrollment date:

Provider Information:

Your name:
Organization name:
Address:
Phone:
Email:

Reason for Disenrollment:

Please enter the reason for disenrollment:	☐ Member enrolled in hospice ☐ Member is deceased ☐ Member condition improved ☐ Member is no longer enrolled with Blue Shield Promise ☐ Other: _____ _____

Please fax the completed form to (323) 889-2109 or secure email to BSCPHP_PalliativeCare@blueshieldca.com.