Provider Leave of Absence Notification

Provider Leave of Absense may not exceed 13 months.

Section 1: Provider Information

Provider Name *(First, Middle Initial, Last)* | Degree | NPI No.

Street Address

City | State | Zip Code | Contact Phone No. ( )

Leave of Absence Start Date | Expected Return Date | Email Address

Section 2: Leave of Absence and Covering Physician Information

Reason for Leave of Absence

Please provide the name and signature of the physician who has agreed to accept responsibility for your MVP Health Care® members during your Leave of Absence.

☐ **Primary Care Provider**
☐ **Specialist**

Name

Signature

Please provide an explanation of the accommodations made to provide MVP members with access to their medical records during this absence.

Section 3: Certification

By signing below, I hereby certify that the information above is true and accurate in all respects, to the best of my knowledge, information, and belief.

I have read and understand the above certification.

Practitioner Signature

Date

Please return this completed Notification via email to:

East/Massachusetts Region	**eastpr@mvphealthcare.com**
Central Region/Mid-State/Southern Tier New York Region	**centralprdept@mvphealthcare.com**
Vermont Region	**vpr@mvphealthcare.com**
Rochester New York Region	**centralprdept@mvphealthcare.com**
Mid-Hudson New York Region	**centralprdept@mvphealthcare.com**