



MVP Health Care Leave of Absence Notification Form

Practitioner Name: First: _____ Middle Initial: _____ Last: _____

Address: _____

Contact Phone #: (____) _____ Email Address: _____

Leave of Absence Start Date _____ Expected Return Date _____ NPI#: _____

Reason for Request: _____

For PCPs, please provide the name and signature of the physician who has agreed to accept primary care responsibility for your MVP members. **For Specialists**, please provide the name and signature of the physician who has agreed to cover for your MVP membership during your leave of absence.

Physician/Practitioner Name

Physician/Practitioner Signature

Please provide an explanation of the accommodations made to provide MVP members with access to their medical records:

Please Sign and Date the below Certification:

I hereby certify that the information contained in this MVP Health Care Leave of Absence Notification Form is true and accurate in all respects, to the best of my knowledge, information and belief.

I HAVE READ AND UNDERSTAND THE ABOVE CERTIFICATION:

Please return this form via Fax to:

Region	Fax #
East/Massachusetts	1-518-388-2200
Mid-State (Syracuse)	1-315-426-3735
Central (Utica)	1-315-736-7002
South Tier (Binghamton)	1-866-721-9205
Mid-Hudson (Fishkill)	1-845-897-6340
New Hampshire	1-603-647-9607
Vermont	1-802-264-6509
West Region (Rochester/Buffalo)	1-585-327-2289