<PHARMACY NAME>

<ADDRESS>

<CITY, STATE ZIP>

<DATE>

SUBJECT: Termination of Participation

National Supplier Clearinghouse

PO Box 100142

Columbia, SC 29202-3134

Customer Service:

Please accept this letter as my official notice of Termination of the Medicare Participating Physician or Supplier Agreement. My participation agreement should end on December 31, 2017, per the instructions on the CMS 460.

Sincerely yours,

<signature of authorized official>

<FIRST MI, LAST>

Authorized Official

<PHARMACY NAME>

NPI: <NPI>

PTAN: <PTAN>