Infinedi
ELECTRONIC DATA INTERCHANGE

Cancel Account Request Form

Please complete one cancellation form for each account to be canceled.

Provider/Practice Name: _____ Acct #: _____

Address: _____

Address: _____

City: _____ State: _____ 9-digit Zip Code: _____

Phone Number: _____ Fax Number: _____

Effective Date of Cancellation: _____

Name and Title of Person Authorizing Cancellation: _____

Please List Reason for Cancellation: _____

_____

_____

_____

_____

_____

_____ _____

Signature of Person Authorizing Cancellation Date

OFFICE USE ONLY

Ticket #: _____

Date Marked Inactive in GP/by: _____

Date Marked Inactive in CM/by: _____

Please Note: Once the account is marked inactive all access to transmit claims will be removed. Reactivation of the account at a later date will require a new setup fee to be paid.

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