

Date: [Date]

To: [Insurance Company Name]

Attn: Appeals/Referral Department

Fax/Address: [Fax Number or Address]

RE: Request for Out-of-Network Continuity of Care Specialist Referral

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a "Continuity of Care" authorization for [Patient Name] to continue treatment with [**Provider Name**], an out-of-network specialist at [**Practice Name**]. This request is based on medical necessity and the need for clinical stability.

Clinical Justification:

The patient has been under the care of [Provider Name] since [Start Date] for the management of [Diagnosis/Condition]. This provider is uniquely qualified to manage this case because [Reason: e.g., rare condition, specialized surgical follow-up, or high-risk pregnancy].

Status of Treatment:

The patient is currently in an active course of treatment including [List treatments: e.g., chemotherapy, post-operative recovery, complex medication titration]. Transitioning to an in-network provider at this stage would pose a significant risk to the patient's health and outcome by causing [List risks: e.g., delay in care, loss of clinical data, or worsening of symptoms].

Request:

I am requesting that [Provider Name] be authorized to provide care at the in-network benefit level for a period of [Number] days/months to ensure the safe completion of this treatment phase.

Thank you for your prompt attention to this matter. I am available at [Phone Number] to discuss this clinical necessity further.

Sincerely,

[Doctor Name, MD/DO]

[NPI Number]

[Practice Name]