

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Phone Number]  
[Email Address]  
[Date]

[Name of Health Insurance Company]  
[Attn: Appeals Department]  
[Address]  
[City, State, Zip Code]

**RE: Continuity of Care Appeal**

Patient Name: [Patient Name]

Member ID: [ID Number]

Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally appeal the denial of my request for Continuity of Care regarding my ongoing treatment with [Doctor/Provider Name]. I was recently notified that this provider is no longer considered in-network as of [Date].

I am requesting that [Insurance Company Name] allow me to continue seeing [Doctor/Provider Name] at the in-network benefit level for a transitional period of [Number] days. I believe this is medically necessary because I am currently undergoing active treatment for the following condition(s):

- [List specific condition, e.g., Pregnancy - Third Trimester]
- [List specific condition, e.g., Post-operative recovery]
- [List specific condition, e.g., Active chemotherapy/radiation]
- [List specific condition, e.g., Chronic condition management]

Abruptly changing my provider at this stage of my treatment would disrupt my care plan and potentially lead to adverse health outcomes. [Doctor/Provider Name] has an intimate knowledge of my medical history and is currently managing a complex course of treatment that cannot be easily transferred to a new provider without significant risk.

Attached, please find supporting documentation from my provider detailing my current treatment plan and the necessity of maintaining continuity of care.

Thank you for your prompt attention to this matter. I look forward to your response within the timeframe required by law.

Sincerely,

[Your Signature]

[Your Printed Name]