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

[Date]

[Insurance Company Name]
[Appeals Department]
[Insurance Address]
[City, State, Zip Code]

RE: Continuity of Care Request / Appeal
Patient Name: [Patient Name]
Member ID Number: [Member ID]
Claim/Reference Number: [Reference Number, if applicable]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for out-of-network services and to request a "Continuity of Care" (or Transition of Care) authorization to continue seeing my current provider, [Provider Name], for a period of [Number of days, e.g., 90 days].

I have been under the consistent care of [Provider Name] since [Start Date] for the treatment of [Specific Diagnosis or Condition]. Because this is an ongoing and complex medical condition, transitioning to a new in-network provider at this stage would significantly disrupt my treatment plan and potentially jeopardize my health.

I am requesting this exception based on the following reasons:

- [Reason 1: e.g., I am currently in the middle of an active course of treatment.]
- [Reason 2: e.g., This provider has specific expertise required for my rare condition.]
- [Reason 3: e.g., I am in my second/third trimester of pregnancy.]
- [Reason 4: e.g., A change in providers would cause clinical instability.]

Attached you will find a letter of medical necessity from my provider, along with relevant clinical notes that document the importance of maintaining this specific patient-provider relationship during this period.

I request that [Insurance Company Name] allow me to continue treatment with [Provider Name] at the in-network benefit level until [Date or End of Treatment Phase].

Thank you for your timely consideration of this request. I look forward to your written response within [Number of days required by law/policy] days.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents, e.g., Provider Letter, Medical Records]