Date: [Date]

To: [Insurance Company Name / Medical Review Department]
Attn: [Case Manager or Appeals Department]
Fax/Address: [Fax Number or Address]

RE: Continuity of Care Protocol Override Request

Patient Name: [Patient Full Name]
Member ID: [Member ID Number]
Date of Birth: [Patient DOB]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a Continuity of Care Protocol Override for [Patient Name]. This request is to allow the patient to continue treatment with [Provider Name/Facility Name], who is currently considered out-of-network, for a transitional period of [Number] days.

The patient is currently undergoing active treatment for the following condition(s):
[List Medical Condition/Diagnosis]

Clinical Justification:
An override is medically necessary because [Patient Name] is currently in the middle of a complex course of treatment. Specifically:

- The patient is in their [Number] trimester of pregnancy.
- The patient is receiving active chemotherapy or radiation.
- The patient is scheduled for surgery on [Date].
- A change in the treating physician at this critical juncture would cause a significant disruption in care and pose a risk to the patient's health outcomes.

Provider Information:
Provider Name: [Provider Name]
NPI Number: [NPI Number]
Tax ID: [Tax ID]
Phone Number: [Phone Number]

We request that [Insurance Company Name] authorize coverage at the in-network benefit level to ensure the safety and stability of the patient's clinical status. Attached please find supporting clinical documentation and the current treatment plan.

Thank you for your immediate attention to this matter. We look forward to your written response within [Number] business days.

Sincerely,

[Physician Signature]
[Physician Name and Title]
[Practice/Facility Name]