[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: Notice of Discharge from Pain Management Services

Dear [Patient Name],

This letter is to formally notify you that we are unable to continue your pain management care at [Clinic Name] effective [Date], due to the loss or termination of your insurance coverage.

Because your current treatment plan may include regulated medications or specialized procedures, it is essential that you establish care with a new provider to avoid any interruption in your treatment. To assist with this transition, we will provide you with a final 30-day supply of your current medications, ending on [Date]. No further refills or appointments will be scheduled after this time.

We recommend you contact your insurance carrier or your primary care physician immediately to find an in-network provider. If you choose to self-pay for future visits, please contact our billing office at [Phone Number] before your next scheduled appointment.

Your medical records are available to be transferred to your new physician. Please sign the enclosed authorization form and return it to our office so we may forward your files promptly.

If you experience a medical emergency or a severe increase in pain during this transition, please proceed to the nearest emergency room.

Sincerely,

[Physician Name/Clinic Administrator]
[Clinic Name]