[Date]

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

Subject: Notice of Expiration of Continuity of Care Period

Dear [Patient Name],

This letter is to inform you that the temporary Continuity of Care period for your treatment with [Provider/Facility Name] will expire on [Expiration Date].

As previously discussed, this transition period was granted to ensure uninterrupted treatment following [Reason for transition, e.g., provider leaving network]. After the date mentioned above, services provided by [Provider Name] will no longer be covered under the Continuity of Care arrangement.

Status of Your Account:

Our records indicate that there is an outstanding balance of $[Amount] on your account for services rendered during this period. We kindly request that you settle this balance or contact our billing department to establish a payment plan by [Due Date].

Next Steps:

- To settle your account, please call our billing office at [Phone Number] or visit [Payment Website].
- If you require assistance transferring your care to an in-network provider, please contact your insurance carrier's member services department at the number listed on your ID card.
- If you believe you have received this notice in error or have already made a payment, please disregard this letter or provide us with the confirmation details.

We have valued the opportunity to participate in your care. Please ensure your account is settled promptly to avoid further collection actions.

Sincerely,

[Sender Name/Department]
[Organization Name]
[Contact Phone Number]