[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

Subject: Notice of Termination of Care due to Insurance Network Status

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the provider-patient relationship with you effective [Date - 30 days from letter date].

This decision is necessary because our practice is no longer an in-network provider with your insurance plan, [Insurance Company Name]. We have determined that we can no longer provide services to you on an out-of-network basis.

We will continue to provide care for you for the next 30 days, until [Date], for emergency or urgent needs only. This time is intended to allow you to find a new healthcare provider who participates in your insurance network.

We recommend contacting your insurance carrier directly or visiting their website to locate an in-network provider in your area. Upon your written authorization, we will transfer a copy of your medical records to your new provider to ensure a smooth transition of care.

Thank you for the opportunity to have served your healthcare needs. We wish you the best in your future care.

Sincerely,

[Provider Name/Signature]
[Title]