[Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

[Patient Name]
[Patient Address]

Subject: Notice of Termination of Medical Care

Dear [Patient Name],

We are writing to inform you that [Clinic Name] will no longer be a participating provider with [Insurance Plan Name] effective [Date].

Because we do not participate in your new insurance network, we are unable to continue providing you with medical services. This letter serves as formal notice that our physician-patient relationship will terminate on [Date of Termination, typically 30 days from date of letter].

Until that date, we will remain available to provide you with emergency care and necessary refills. This period is intended to give you sufficient time to locate a new healthcare provider who accepts your current insurance plan.

We recommend contacting your insurance carrier directly or visiting their website to find a list of in-network providers in your area. Once you have selected a new physician, please sign the enclosed medical record release form and return it to our office. We will then 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 participated in your healthcare. We wish you the best in your future medical endeavors.

Sincerely,

[Doctor Name/Clinic Administrator]
[Clinic Name]