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

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

Subject: Important update regarding your health insurance coverage

Dear [Patient Name],

We are writing to inform you of an upcoming change regarding our participation in your health insurance provider's network. As of [Date], [Doctor or Practice Name] will no longer be an in-network provider for [Insurance Company Name/Plan Name].

We value your health and our relationship with you. Because of this change, we want to ensure you have the necessary information to manage your ongoing care:

- **Current Appointments:** If you have an appointment scheduled after [Date], please contact our office to discuss your options.
- **Out-of-Network Benefits:** Some plans allow you to see providers outside of the network at a different cost. Please contact [Insurance Company Name] to see if your plan includes these benefits.
- **Medical Records:** If you choose to transition your care to a new provider, we will assist in transferring your medical records. You may request a transfer form by calling [Phone Number].
- **Continuity of Care:** If you are currently undergoing active treatment (such as pregnancy or surgery recovery), you may be eligible for temporary "Continuity of Care" coverage. Please contact your insurance provider immediately to request this.

We understand that insurance changes can be difficult. If you have questions regarding your account or wish to discuss self-pay options to remain with our practice, please call our billing department at [Phone Number].

It has been a pleasure serving as your healthcare provider.

Sincerely,

[Doctor Name/Practice Manager Name]
[Practice Name]