[Date]

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

RE: Notice of Discharge due to Out-of-Network Insurance Status

Dear [Patient Name],

This letter is to formally notify you that [Practice/Provider Name] will no longer be able to provide ongoing treatment to you effective [Date of Discharge].

This decision has been made because our facility is not a participating provider in your current insurance plan, [Insurance Company Name]. As an out-of-network provider, the cost of continued care may result in significant financial hardship for you, or your insurance may no longer authorize services at this location.

To ensure your continuity of care, we recommend the following steps:

- Contact your insurance provider to request a list of in-network providers.
- Review your "Evidence of Coverage" for information on transferring care.
- Request a copy of your medical records from our office to provide to your new clinician.

We are available to provide [Number of Days, e.g., 30 days] of emergency care or transitional support from the date of this letter to allow you time to secure a new provider. After [Date of Discharge], our professional relationship will be officially terminated.

Please find an authorization for release of medical records form enclosed. Once signed and returned, we will forward your history to your new provider immediately.

We wish you the best in your continued health and recovery.

Sincerely,

[Provider Signature]
[Provider Name/Title]
[Practice Name]