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

[Date]

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

Re: Notice of Termination of Care Due to Insurance Network Changes

Dear [Patient Name],

We are writing to formally notify you that [Practice Name] will no longer be a participating provider in the [Insurance Plan Name] network, effective [Date].

Because we will no longer be in-network with your insurance provider, we are unable to continue providing you with medical services after [Final Date of Service]. This decision was necessitated by changes in our contractual agreements with insurance carriers.

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

- Contact [Insurance Plan Name] member services at the number on your ID card to find a participating provider in your area.
- Request a copy of your medical records. You may sign the attached authorization form and return it to our office so we may transfer your records to your new physician.

If you have an appointment scheduled after [Date], our office will contact you to cancel or help you transition your care. If you are currently experiencing an acute medical issue or are in the middle of a specific treatment cycle, please contact us immediately so we can discuss a safe transition plan.

It has been a pleasure caring for you, and we wish you the best in your future health endeavors.

Sincerely,

[Physician/Provider Name]
[Practice Name]