[Date]

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

Re: Notice of Termination of Provider-Patient Relationship

Dear [Patient Name],

This letter is to formally notify you that [Provider Name/Practice Name] will no longer be participating in the [Insurance Plan Name] network, effective [Date of Network Change].

Due to this change in network status and administrative restructuring, I must inform you that I will no longer be able to serve as your healthcare provider effective [Final Date of Care, typically 30 days from date of letter].

Continuity of Care:
If you are currently undergoing an active course of treatment (such as pregnancy, terminal illness, or a scheduled surgery), you may be eligible for "Continuity of Care" benefits through your insurance provider. This would allow you to continue seeing me for a specific period at your current in-network benefit level. Please contact [Insurance Plan Name] at [Insurance Phone Number] immediately to request the necessary transition forms.

Medical Records:
Your medical records are confidential. We can transition your records to a new provider of your choice upon receipt of a signed authorization form. I have enclosed an authorization form for your convenience.

Finding a New Provider:
To find a new provider within your insurance network, please:

- Contact the member services number on the back of your insurance card.
- Visit the [Insurance Plan Name] online provider directory.
- Contact your local medical society for recommendations.

During this transition period, I will remain available to provide emergency care and necessary prescriptions until [Final Date of Care]. After this date, you must seek care from your new provider.

Thank you for the opportunity to have participated in your healthcare.

Sincerely,

[Provider Signature]
[Provider Name]
[Practice Name]