[Date]

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

Subject: Important Information Regarding Your Health Insurance Coverage

Dear [Patient Name],

We are writing to inform you of an upcoming change regarding the insurance networks accepted by [Practice Name]. Effective [Date], our practice will no longer be a participating provider in the [Insurance Company Name] [Specific Plan Name, e.g., PPO/HMO] network.

What this means for you:

- After [Date], services provided at our office will be considered "out-of-network" by your current insurance plan.
- Depending on your specific policy, this may result in higher out-of-pocket costs or a requirement to find a new primary care provider/specialist within your network.

Your options for continuing care:

1. **Stay with our practice:** You may continue to receive care here as an out-of-network patient. Please contact your insurance provider to understand your out-of-network benefits and potential costs.
2. **Transition to a new provider:** If you choose to move to an in-network provider, we are committed to making this transition as smooth as possible. We will transfer your medical records to your new physician upon receipt of a signed authorization form.
3. **Check other accepted plans:** We continue to participate in many other insurance networks. If you are changing insurance during an open enrollment period, please contact our billing office to verify which plans we accept.

If you are currently undergoing an active course of treatment (such as pregnancy or post-surgical care), you may be eligible for "Continuity of Care" benefits through your insurer, which allows you to see us at in-network rates for a limited time. Please contact [Insurance Company Name] immediately to request this.

We value your trust in us and regret any inconvenience this may cause. If you have questions regarding your account or medical records, please call our office at [Phone Number].

Sincerely,

[Doctor/Administrator Name]
[Practice Name]
[Phone Number]