[Date]

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

Subject: Notice of Termination of Provider-Patient Relationship

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide medical services to you, effective [Date of Termination].

This decision has been made because our practice is no longer a participating provider with your insurance plan, [Insurance Company Name]. As an out-of-network provider, we are unable to continue your care under your current coverage terms.

We will remain available to provide you with emergency care and necessary follow-up treatment for the next 30 days, until [Date 30 days from now]. This window is intended to give you sufficient time to locate a new healthcare provider who is within your insurance network.

To ensure a smooth transition, we recommend the following steps:

- Contact your insurance carrier to obtain a list of in-network providers.
- Contact your new provider as soon as possible to schedule an appointment.
- Sign the attached medical record release form so we may forward your records to your new physician.

Thank you for the opportunity to have served your healthcare needs. We wish you the best in your future health endeavors.

Sincerely,

[Doctor/Provider Name]
[Practice Name]