[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Request for Out-of-Network Transfer of Care / Continuity of Care

Member Name: [Patient Name]
Member ID Number: [ID Number]
Group Number: [Group Number]
Provider Name: [Doctor/Provider Name]
Provider NPI: [Provider NPI Number]

To Whom It May Concern,

I am writing to formally request a "Transfer of Care" (also known as Continuity of Care) transition period to continue treatment with my current provider, [Provider Name], who is now outside of my insurance network. I am requesting that services be covered at the in-network benefit level for a period of [Number, e.g., 90] days.

I am currently undergoing an active course of treatment for the following condition(s): [List Diagnosis or Condition].

I am requesting this transition period because:

- [Option 1: I am in the second or third trimester of pregnancy.]
- [Option 2: I am receiving ongoing treatment for an acute or chronic serious condition.]
- [Option 3: I have a scheduled surgery or procedure on [Date].]
- [Option 4: A sudden change in providers would be detrimental to my clinical health and safety.]

Attached you will find [List supporting documents, e.g., medical records or a letter of medical necessity from your doctor] outlining why a transition to a new in-network provider at this specific time would disrupt my care plan.

Please provide a written determination regarding this request within [Number] business days. I can be reached at [Phone Number] if you require further information.

Sincerely,

[Your Signature]
[Your Printed Name]