

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Important Information Regarding Your Insurance and Care Transfer

Dear [Patient Name],

We are writing to inform you of an upcoming change regarding our participation with your insurance provider. Effective [Date], [Practice/Provider Name] will no longer be an in-network provider for [Insurance Plan Name].

Because we want to ensure you receive uninterrupted medical care, we are initiating a transfer of care process. You have the following options:

- **Transfer to a New Provider:** We can assist in transferring your medical records to a new in-network provider of your choice. Please complete the enclosed "Authorization to Release Medical Records" form.
- **Out-of-Network Care:** If your plan allows for out-of-network benefits, you may choose to continue seeing us; however, please be aware that your out-of-pocket costs may increase significantly.
- **Continuity of Care:** In certain cases (such as pregnancy or active treatment for a chronic condition), your insurance may grant a "Continuity of Care" waiver to allow temporary in-network coverage. Please contact [Insurance Plan Name] at [Phone Number] to inquire about eligibility.

Your last scheduled appointment with us is on [Date of Last Appointment]. To help with this transition, we have identified the following local in-network providers who are currently accepting new patients:

- [New Provider/Clinic Name 1] - [Phone Number]
- [New Provider/Clinic Name 2] - [Phone Number]

We have valued the opportunity to manage your healthcare needs. If you have any questions regarding this transition or the transfer of your medical records, please call our office at [Office Phone Number].

Sincerely,

[Provider/Administrator Name]

[Practice Name]