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

[Date]

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

RE: Request for Continuity of Care / Transition of Care
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Provider Name: [Out-of-Network Provider Name]

To Whom It May Concern,

I am writing to formally request a "Transfer of Care" (Continuity of Care) authorization to continue treatment with my current provider, [Provider Name], who is currently outside of my insurance network.

I am currently undergoing an active course of treatment for [Specific Medical Condition/Diagnosis]. It is medically necessary for me to continue treatment with this provider because:

- [Reason 1: e.g., Long-standing clinical relationship]
- [Reason 2: e.g., Specialized treatment not available in-network]
- [Reason 3: e.g., Mid-course of a high-risk pregnancy or surgical recovery]

I request that [Insurance Company Name] cover my visits with [Provider Name] at the in-network benefit level and cost-sharing rate for a period of [Number of Days, e.g., 90 days] to ensure there is no disruption to my medical stability.

Attached you will find [List supporting documents, e.g., a letter of medical necessity from the doctor, treatment plan].

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

Sincerely,

[Your Signature]

[Your Printed Name]