

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

[Date]

[New Insurance Company Name]
[Attn: Continuity of Care Department / Appeals Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Request for Continuity of Care / Transition of Care Coverage

Subscriber Name: [Name of Primary Policy Holder]
Member ID Number: [Your Member ID]
Group Number: [Your Group Number]

To Whom It May Concern,

I am writing to formally request a "Continuity of Care" transition period for my ongoing medical treatment. My health insurance coverage recently changed to [New Insurance Company Name], effective [Date Coverage Started].

I am currently receiving active treatment for the following condition(s): [List Medical Condition/Diagnosis].

My current treating provider is out-of-network with my new plan:

Provider Name: [Doctor's Name]
Specialty: [Specialty]
Facility/Clinic Name: [Clinic Name]
Phone Number: [Doctor's Phone Number]

I am in the middle of a specific course of treatment, which includes: [Mention specific treatments, e.g., chemotherapy, post-surgical follow-up, 3rd trimester pregnancy, or scheduled surgery].

Disrupting this care or transferring to a new provider at this stage would pose a significant risk to my health and the success of my treatment. Therefore, I am requesting that you authorize continued coverage with my current provider at the in-network benefit level for the duration of this transition period (typically 60 to 90 days).

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

Please process this request as soon as possible and notify me in writing of your decision. If you require further information, I can be reached at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]