Date: [Date]

To: [Insurance Provider Name]
Department: [Claims/Prior Authorization Department]
Address: [Insurance Company Address]

RE: Transfer of Care / Transition of Services

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID Number: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

This letter serves as formal notification regarding the transfer of care for the above-mentioned patient. The patient is transitioning their specialized medical management from [Previous Clinic/Provider Name] to our facility, [Your Clinic Name].

Clinical Justification:
The patient requires ongoing treatment for [Diagnosis/Medical Condition]. To ensure continuity of care and prevent clinical regression, it is necessary for the patient to establish services with [Provider Name] at our clinic effective [Start Date].

Requested Action:
We request that you update the patient's file to reflect [Your Clinic Name] as the active treating specialist. Please provide information regarding:

- Current authorization status for [Specific Procedure/Treatment].
- Requirements for new referrals or prior authorizations under the patient's current plan.
- Effective dates for coverage at this location.

Attached you will find the patient's signed Release of Information (ROI) and relevant medical records from the previous provider.

If you require further clinical documentation or have questions regarding this transition, please contact our administrative office at [Phone Number] or [Email Address].

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Clinic Name]
[NPI Number]
[Tax ID Number]