

Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [Date of Birth]

Policy Number: [Policy Number]

To: [New Insurance Company Name / Medical Director]

Address: [Insurance Company Address]

Subject: Formal Request for Continuity of Care - [Diagnosis Name]

Dear Continuity of Care Department,

I am writing to formally request a "Transition of Care" or "Continuity of Care" coverage period. Due to a recent change in my insurance provider, my current healthcare provider, [Doctor's Name], is now considered out-of-network.

I am currently undergoing active treatment for the following chronic condition(s):

- [Condition 1]

- [Condition 2]

Interrupting my current treatment plan or switching providers at this stage would pose a significant risk to my health and clinical stability. I am requesting that [Insurance Company Name] authorize me to continue treatment with [Doctor's Name/Facility Name] at the in-network benefit level for a period of [Number, e.g., 90] days.

This extension will allow for:

- Completion of the current phase of my treatment plan.
- A safe and coordinated hand-off of my medical records to an in-network specialist.
- Prevention of complications or emergency hospitalizations due to a gap in specialized care.

Attached you will find [List any documents, e.g., current treatment plan or physician letter] supporting this medical necessity.

Please provide a written determination regarding this request by [Date]. I can be reached at [Phone Number] or [Email Address] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]