[Date]

[Insurance Provider Name]
[Claims/Authorization Department]
[Address]
[City, State, Zip Code]

RE: Notice of Transfer of Care

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

This letter is to formally notify you of a transfer of care for the above-mentioned pediatric patient. Effective [Date], the patient is transitioning their medical management and primary care services.

Relinquishing Provider/Facility:
[Name of Previous Doctor/Clinic]
[Phone Number]

Receiving Provider/Facility:
[Name of New Doctor/Clinic]
[Address]
[Phone Number]

Reason for Transfer:
[Example: Relocation / Change in insurance network / Transition to specialist]

Please update your records to reflect [New Provider Name] as the Primary Care Provider (PCP) of record to ensure uninterrupted coverage and authorization for upcoming appointments, prescriptions, and necessary referrals. We request that all active prior authorizations be transferred to the new provider to maintain continuity of care.

If you require additional documentation or a signed medical release form, please contact [Parent/Guardian Name] at [Phone Number].

Sincerely,

[Signature]
[Printed Name of Parent or Legal Guardian]
[Relationship to Patient]