

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Insurance Company Name]
Attn: Continuity of Care Department
[Insurance Company Address]

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

Patient Name: [Patient Name]
Member ID Number: [New Member ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a "Transition of Care" or "Continuity of Care" benefit due to a recent change in my employer-sponsored health insurance. My coverage recently switched from [Old Insurance Company Name] to [New Insurance Company Name].

I am currently undergoing an active course of treatment with a provider who is not in your network. Interrupting this care would pose a significant risk to my health and treatment outcome.

Provider Information:

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

Medical Condition/Treatment:

I am receiving treatment for: [Brief description of condition, e.g., third-trimester pregnancy, chemotherapy, postsurgical recovery]. My current treatment plan began on [Date] and is expected to continue through [Date].

I request that [New Insurance Company Name] allow me to continue seeing this provider at the in-network benefit level for the duration of this specific treatment cycle (typically 90 days), as provided under the No Surprises Act or applicable state continuity of care laws.

Please find the attached medical documentation supporting this request. I look forward to your written response regarding the approval of this transition period within [Number] days.

Sincerely,

[Your Signature]

[Your Printed Name]