

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Important Update Regarding Your Health Insurance Coverage

Dear [Patient Name],

We are writing to inform you that effective [Date], [Practice/Provider Name] will no longer be an in-network provider for [Name of Insurance Plan].

We value the relationship we have built with you. However, because we will soon be out-of-network, continuing your care at our facility may result in higher out-of-pocket costs for you. To ensure your care remains affordable and uninterrupted, we recommend transitioning your records to a provider within your insurance network.

To assist with this transition, we are prepared to:

- Provide you with a copy of your medical records.
- Transfer your records directly to your new provider upon receipt of a signed authorization form.
- Provide a final refill of essential medications (if applicable) to cover you during the transition period.

To find a new in-network provider, please contact [Name of Insurance Plan] at [Insurance Phone Number] or visit their website at [Insurance Website].

If you choose to continue seeing us as an out-of-network patient, please contact our billing office at [Phone Number] to discuss our self-pay rates and payment policies.

It has been a pleasure caring for you. We wish you the very best in your future health and wellness.

Sincerely,

[Provider/Admin Name]

[Practice Name]

[Phone Number]