

Date: [Date]

RE: Transfer of Care for [Patient Name]

Patient Date of Birth: [DOB]

Insurance Carrier: [Insurance Company Name]

Policy/Member ID: [ID Number]

Authorization Number: [Auth Number]

Dear [Receiving Physician/Provider Name],

This letter is to formally transfer the medical care of [Patient Name] to your practice, effective [Date].

We have received formal authorization from [Insurance Company Name] for this transfer. This approval covers the following services: [List Approved Services/Consultations].

Clinical Summary:

The patient is being referred for [Reason for Transfer/Diagnosis]. Attached to this letter, please find the patient's medical records, including current medications, recent lab results, and the formal insurance authorization document.

Current Treatment Plan:

[Brief Description of Ongoing Treatment]

Referring Provider Information:

Name: [Referring Doctor Name]

Phone: [Phone Number]

Fax: [Fax Number]

Please contact our office if you require any additional documentation to ensure a seamless transition for the patient.

Sincerely,

[Your Name/Signature]

[Title]

[Practice Name]