

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

[Date]

[Insurance Company Name]  
[Insurance Company Address]  
[City, State, Zip Code]

**RE: Notice of Out-of-Network Provider Transfer**

To Whom It May Concern,

I am writing to formally notify [Insurance Company Name] that I am transferring my care from my current out-of-network provider to an in-network provider. This transition is being made to ensure my treatment remains within my plan's designated network benefits.

**Patient Information:**

Patient Name: [Patient Full Name]  
Policy/Member ID: [Policy Number]  
Group Number: [Group Number]

**Current Out-of-Network Provider:**

Provider Name: [Current Provider Name]  
Facility Name: [Facility Name]  
Last Date of Service: [Date]

**New In-Network Provider:**

Provider Name: [New Provider Name]  
Facility Name: [Facility Name]  
Effective Date of Transfer: [Date]

Please update my records to reflect this change. I have requested that my medical records be transferred from [Current Provider Name] to [New Provider Name] to ensure continuity of care.

If there are any specific forms or additional documentation required to facilitate this transfer or to update my authorizations, please let me know as soon as possible.

Thank you for your assistance in this matter.

Sincerely,

[Your Signature]

[Your Printed Name]