Date: [Date]

To: [Receiving Provider/Facility Name]
Department: Gastroenterology
Address: [Facility Address]
Phone: [Phone Number]

RE: Patient Transfer and Medical Records Request

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance Provider: [Insurance Name]
Member ID: [Member ID Number]

To Whom It May Concern,

I am writing to formally transfer the gastroenterology care of the above-named patient from [Current Practice Name] to your facility. This transfer is being initiated because our practice is currently out-of-network for the patient's insurance provider, and the patient requires continued care within their network to manage their condition.

Current Diagnosis/Reason for Care:
[Insert Primary Diagnosis, e.g., Crohn's Disease, Ulcerative Colitis, GERD, Chronic Liver Disease]

Brief Clinical History:
[Summary of current symptoms, recent procedures, and medications]

Requested Action:
We request that your office schedule the patient for an initial consultation to establish care. Attached to this letter, please find the following medical records to assist with the transition:

- Most recent clinical notes and summary of care
- Recent laboratory results and pathology reports
- Latest endoscopy/colonoscopy reports and images
- Current medication list and infusion history (if applicable)
- Imaging results (CT, MRI, Ultrasound)

If you require additional documentation or have questions regarding the patient's history, please contact our office at [Phone Number].

Thank you for your assistance in ensuring the continuity of this patient's care.

Sincerely,

[Provider Signature]
[Provider Name, Title]
[Current Practice Name]