<<IPA LOGO>>

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

NOTICE TO END CONTINUITY OF CARE

DOB:	[Member DOB]
Member ID:	[Member ID]
Health Plan:	IEHP DualChoice (HMO D-SNP)
Requesting Provider:	[Requesting Provider Name]
Requested Provider:	[Servicing Provider Name]
Authorization/Precertification Number:	[medHOK Reference #]

Dear [Member Name]:

We hope this letter finds you well. We are writing to let you know your continuity of care (staying with a Provider outside of our network for up to twelve months from the day you enroll with IEHP DualChoice) with <insert servicing provider name> for <service category> will end on <thru date from procedure box>.

As an <<IPA>> Member, you can choose a new Provider at any time. For a list of in-network Providers, you can view the <<IPA>> Provider Directory at <<IPA website>> or call <<IPA> Member Services.

If you need help finding a Provider that is within our network or if you have any questions or concerns, please call <<IPA>> Member Services <<IPA Phone Number>>, <<IPA Hours of Operation>>. TTY users should call <<IPA TTY Number>>.

While there has been a change to your care, all your IEHP DualChoice benefits are the same. Thank you for being a valued Member of <<IPA>> and for trusting us with your health care needs.

To your health,

<<IPA>>

CC: [Requesting Provider Name]
[Servicing Provider Name]

Requested Provider: The service is approved only if the Member is eligible at the time of service. You may verify this online at **www.iehp.org** or by calling (909) 890-3800 (IVR) or (888) 440-4340 (Phone).

IEHP DualChoice (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.