Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Your health plan is the Central California Alliance for Health (the Alliance). I have asked the Alliance if I can stop seeing you as a patient. I did this because:

|  |  |
| --- | --- |
|  I believe you have committed fraud or theft |  You have not followed your treatment plan |
|  You have asked for medication I don’t feel is medically necessary |  I don’t feel we can have a good doctor/patient relationship |
|  You have displayed abusive or disruptive behavior |  You have not kept your appointments |
| You have broken your Medication Management Agreement |  Other (as described below) |

Until the Alliance makes a decision, I will still be your Primary Care Provider (PCP). I will still be responsible for your medical care.

If the Alliance approves my request, I will no longer be your PCP. The Alliance will call you or send you a letter to tell you their decision. The Alliance will let you know when this change will be effective and will help you choose another PCP.

Please feel free to contact me at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, if you have any questions.

If you would like to speak to someone at the Alliance regarding this letter, you may call Member Services at 1-800-700-3874. If you need language assistance, we are able to get an interpreter on the phone who speaks your language. For the Hearing or Speech Assistance Line (TTY: Dial 7-1-1).

Sincerely,