

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

**RE: Change in Hospital Affiliation**

Dear [PCP Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting a hospital affiliation change from [Old Hospital Name] to [New Hospital Name].

In compliance with IEHP’s Provider Policy and Procedure Manual, your affiliation with [New Hospital Name] will become effective [Date]. According to IEHP Provider Policy and Procedure Manual, this change is considered compliant.

If you need assistance or clarification, please feel free to contact me at [Phone #].

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Hospital]

[IPA]

 [First Name, Last Name], Chief Operating Officer, IEHP

 [First Name, Last Name], Director of Provider Relations, IEHP

 [IPA File]

 [PCP File]