

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

**RE: Change in IPA Affiliation**

Dear Dr. [PCP Name]:

This is to acknowledge receipt of your letter dated [Date of Letter], requesting that your IPA affiliation be changed to [New IPA Name].

In compliance with IEHP Provider Policy and Procedures, provided there are no credentialing or contract issues, this change will be made effective on the 1st of the month following 60 days from notification - [Effective Date]. Please be advised that though this is an IEHP Policy (18C), you may have different commitments under your contractual agreement with [Old IPA Name].

Administrative issues will remain the responsibility of [Old IPA Name] through [End Date].

If you have questions or concerns, please contact me at [PSR Phone Number].

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Old IPA Name]

[New IPA Name]

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

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

[IPA File]

[PCP File]