

[Date]

[IPA NAME]

[ADDRESS]

[CITY, STATE ZIP]

**RE: [PCP Name] TERMINATION**

Dear [IPA Contact Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting the termination of Dr. [Doctor Name] from the IEHP network. Dr. [Doctor Name] will be terminated as an IEHP PCP within [IPA Name] effective [Date] and [his/her] patients will be reassigned to Dr. [New Doctor Name], effective [Date].

Under IEHP Policy 18D, the IPA is required to give IEHP a 60-day advance written notice. This notification of termination is compliant since a 60-day advance written notice was provided.

If you have any questions or concerns, please call the Provider Call Center at 909-890-2054 or email ProviderUpdates@iehp.org.

Sincerely,

 PNS Name Provider Network Specialist II

cc: [PCP Name]

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

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

 [PCP File]