[Date]

[IPA Contact Name]

[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 [PCP Name] as a PCP from [PCP Address]. Dr. [PCP Name] membership will be reassigned to Dr. [New PCP Name] to the same location effective [Date].

Under IEHP Policy 18.D, the IPA is required to give IEHP a 60-day advance written notice. This notification of termination is non-compliant due to no 60-day advance written notice was provided.

Because of this requirement IEHP retains the right to obligate the IPA to provide medical services for the PCP’s existing patients at the former PCP practice location for up to 60 days. If patient care becomes an issue, efforts will be made to reassign the patients to another PCP; however, there is no guarantee that all patients will remain within your network.

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