<<Date>>

```
<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>>
```

## NOTICE OF AUTHORIZATION- CONTINUITY OF CARE

**DOB:** [Member DOB]

Member ID: [Subscriber ID or Subscriber Dependent #]

Health Plan:

Requesting Provider:

Requested Provider:

Authorization/Precertification Number:

IEHP DualChoice (HMO D-SNP)

[Requesting Provider Name]

[Servicing Provider Name]

[Authorization or Referral #]

## Dear [Member Name]:

We hope this letter finds you well. We are writing to let you know your request for continuity of care (staying with a provider outside of our network for up to twelve months from the day you enrolled with IEHP DualChoice) for <service category> with <servicing provider name> has been approved. This means you can stay with your current provider.

Authorization Valid from/to: <MM/DD/YYYY / MM/DD/YYYY>

**Authorized Provider: <Servicing provider Name> <Servicing Provider Phone** 

Number>

As an <<IPA>> member, you have the right to choose a different provider from our network at any time. For a list of providers, you can view the <<IPA>> provider directory at <<IPA website>> or call <<IPA>> Member Services at <<IPA Phone Number>>, <<IPA Hours of Operation>>. TTY users should call <<IPA TTY Number>>.

<<IPA>> will contact you before the end date above to help you move to a provider that is within the <<IPA>> network.

If you have any questions or concerns, please call <<IPA>> at <<IPA Phone#>>, <<Hours of Operation>>. TTY users should call <<TTY#>>.

Thank you for being a valued member of <<IPA>> and trusting us with your health care needs.

To your health,

<<IPA>>

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CC: [Requesting Provider]
[Requested Provider]
[PCP]

**Requested Provider:** The service is approved only if the member is eligible at the time of service. You may verify this online at *www.iehp.org*.

IEHP DualChoice (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.