MONTH DATE, YEAR

**McLaren Region -**

**Office Name**

STREET ADDRESS, SUITE #

CITY, MI ZIP

tel: (000) 000-0000

fax: (000) 000-0000

mclaren.org/officeURL

Dear patient:

As I begin my X year as a XXXX specialist in City, I recognize I am aging, and I need a change. Although I continue to love the practice of medicine and feel it is a great privilege to care for all of you, I am limiting my practice to describe change (days, hours, patient care, etc.).

If your health insurance requires the designation of a primary care provider, you will need to contact your insurance company to declare your new selection.

Please be assured we are committed to maintaining continuity of care for you and your family. Should this change lead you to seek a new provider or additional care, below is a list of McLaren Medical Group providers that will offer you high-quality, patient-centered care.

|  |  |  |  |
| --- | --- | --- | --- |
| Provider | Specialty | Office | Telephone |
| First Last, Credential | Specialty | **Location Name**  Address | (000) 000-0000 |
| First Last, Credential | Specialty | **Location Name**  Address | (000) 000-0000 |
| First Last, Credential | Specialty | **Location Name**  Address | (000) 000-0000 |

*\*IF YOU WISH TO INCLUDE MORE THAN 3 PROVIDERS, PLEASE INSERT ROWS\**

For a complete list of providers and services, please visit mclaren.org/region. If you have questions or want to schedule an appointment, please call our office at

(000) 000-0000.

Thank you for entrusting McLaren with your health care needs.

Sincerely,

*Upload signature(s) in the Special Notes/Attachments section of Request Form.*

First and Last Name, Credential

Specialty

McLaren Medical Group