

[member Name]

Medicaid ID: [xxxxxxxx]

RE: Termination of Provider- Patient Relationship

Dear **[Member Name]**,

This letter is to inform you that **[name of practice]** will no longer be able to serve as your dental provider effective **[date]**.

This decision has been made due to **[insert reason- multiple missed and/or canceled appointments without adequate notice]**. Missed appointments disrupt the care of other patients and make it difficult for our office to provide timely treatment to all individuals in need of care. Despite previous discussions and reminders, this issue has continued.

To ensure continuity of your care, **[name of practice]** agrees to continue providing emergency coverage of your healthcare needs for up to 45 days from the date of this letter, or until you have established care with another provider, whichever occurs first.

We encourage you to contact DentaQuest Member Services at 855-225-1729 (State Relay 711) between the hours of 8 am to 5 pm Mountain Time or go to [DentaQuest Member Portal](#) to select a new provider as soon as possible. Once you have chosen a new provider, we will gladly transfer your medical/dental records upon receipt of your written authorization. You may request a release form by contacting our office at **[phone number]** or emailing us at **[email address]**.

We wish you the best in your continued health and future care.

Sincerely,

[insert provider /office name]