

[Your Name]

[Your Address]

[Your Phone]

[Your Email]

[Date]

DMHC Help Center
980 9th Street, Suite 500
Sacramento, CA 95814

RE: Urgent Complaint and Independent Medical Review Request - Continuity of Care Denial

Member Name: [Your Name]

Member ID: [Your ID Number]

Health Plan: [Name of Plan, e.g., Blue Shield, Health Net]

Provider: [Name of Non-Contracted Doctor]

To Whom It May Concern,

I am writing to file a complaint regarding [Health Plan Name]'s denial of my continuity of care request (Case # [If available] or Denial Letter Date [Date]).

I have been a patient of Dr. [Doctor Name] for [Number] years/months for the treatment of [Condition]. Dr. [Doctor Name] is no longer in [Health Plan Name]'s network. According to California Health and Safety Code section 1367(d), I am entitled to continuity of care.

Discontinuing care with this provider would [explain risk, e.g., disrupt my treatment plan, cause severe anxiety, or cause a relapse of my condition].

I request an Independent Medical Review (IMR) because the plan has denied me access to a qualified provider for an active condition.

Sincerely,

[Your Signature]

[Your Printed Name]