Payor Contract Termination Letter Template

90-day notice to terminate payor agreement

[YOUR PRACTICE LETTERHEAD]

[DATE]

[PAYOR NAME]
[PAYOR ADDRESS]
[CITY, STATE ZIP]

RE: NOTICE OF CONTRACT TERMINATION
Provider/Group Tax ID: [TAX ID]
Contract Number: [CONTRACT NUMBER]

To Whom It May Concern:

This letter serves as formal notice of [PRACTICE NAME]'s intent to terminate our participating provider agreement with [PAYOR NAME], effective [DATE 90 DAYS FROM TODAY], pursuant to Section [X.X] of the contract dated [ORIGINAL CONTRACT DATE].

Reason for Termination:

[Choose one or customize:]

■ **Low reimbursement rates:** Current fee schedule does not support the cost of providing quality care to your members. Despite multiple requests for rate negotiation, no agreement has been reached.

■ **Administrative burden:** Excessive prior authorization requirements, denial rates exceeding [X]%, and delayed claim payments have created unsustainable administrative costs.

■ **Practice focus change:** Our practice is narrowing its payor mix to align with strategic goals and improve operational efficiency.

■ **Contract non-compliance:** [PAYOR NAME] has not complied with contract terms regarding [SPECIFIC ISSUE], including [EXAMPLE 1] and [EXAMPLE 2]. Despite good-faith efforts to resolve these issues, they remain unaddressed.

Effective Date and Transition:

Effective [DATE 90 DAYS FROM TODAY], [PRACTICE NAME] will no longer accept new patients with [PAYOR NAME] coverage. We will continue to see established patients through [DATE 60 DAYS AFTER TERMINATION] to allow for an orderly transition of care.

Claims and Outstanding Balances:

All claims for dates of service prior to [TERMINATION DATE] must be processed according to the current contract terms. We expect payment of all outstanding claims within 45 days of termination. Any claims denied or delayed beyond this period will be billed directly to the patient as allowed under the terminated contract.

Current outstanding AR balance: $[AMOUNT] (as of [DATE])

Patient Notification:

We will notify affected patients of this change beginning [30 DAYS FROM TODAY]. Patients will be provided with:
• Written notice of contract termination
• List of in-network providers in the area
• Assistance with transition of care and medical records transfer

Next Steps:

Please confirm receipt of this termination notice and provide the following within 15 business days:
1. Written confirmation of termination effective date
2. Final claims submission deadline
3. Outstanding claims report (all pending/unpaid claims)
4. Process for handling claims submitted after termination date
5. Patient notification requirements (if any beyond standard notice)

Contact Information:

For questions regarding this termination, please contact:
[PRACTICE ADMINISTRATOR NAME]
[PHONE]
[EMAIL]

We appreciate the opportunity to serve your members and regret that circumstances have necessitated this decision. We remain committed to ensuring a smooth transition for all affected patients.

Sincerely,

[SIGNATURE]
[PROVIDER NAME, CREDENTIALS]
[PRACTICE NAME]
[TAX ID]
[NPI NUMBER]

cc: Practice Administrator
cc: Legal Counsel (if applicable)
cc: [STATE] Department of Insurance (if required by state law)

IMPORTANT NOTES:

• Review your contract for specific termination requirements (notice period, format, delivery method)
• Some contracts require certified mail or specific delivery method
• Check state laws—some states require 90-180 day notice periods
• Document everything: dates, communications, outstanding AR
• Continue seeing established patients during transition period (60-90 days typical)
• Do NOT stop submitting claims until final submission deadline confirmed by payor