Health Insurance Network Participation Confirmation

Date: [Insert Date]

To: [Provider's Name]

[Provider's Address]

[City, State, Zip Code]

Dear [Provider's Name],

We are pleased to confirm your participation in the [Health Insurance Network Name] as of [Effective Date]. Your inclusion in our network will allow you to provide services to our members and receive appropriate reimbursements for your services.

As a participating provider, you are expected to adhere to the policies and guidelines outlined in the provider manual, which can be accessed [insert link or instructions to access the manual].

For any questions or additional assistance, please contact our provider relations department at [insert contact information].

Thank you for your commitment to delivering quality healthcare to our members.

Sincerely,

[Your Name]

[Your Job Title]

[Health Insurance Network Name]

[Contact Information]