

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Account Number]

[Date]

[Recipient Name or Billing Department]
[Name of Medical Institution]
[Address]
[City, State, Zip Code]

Subject: Request for Financial Hardship Assistance - Account #[Your Account Number]

Dear Billing Department,

I am writing to formally request financial assistance regarding my outstanding medical balance of \$[Amount]. Due to an unexpected medical emergency involving [Briefly state: self/family member], I am currently experiencing severe financial hardship and am unable to pay the full balance at this time.

The emergency occurred on [Date] and resulted in [Briefly mention the situation, e.g., hospitalization/surgery]. This situation has impacted my ability to meet my financial obligations because of [Reason: e.g., loss of income, high out-of-pocket costs, or lack of insurance coverage].

I am committed to resolving this debt and would like to request one of the following options:

- A reduction in the total balance owed based on my income level.
- A long-term interest-free payment plan of \$[Amount] per month.
- Application for your hospital's charity care or financial assistance program.

I have attached [List documents: e.g., recent pay stubs, tax returns, or medical bills] as proof of my current financial status. I am happy to provide any additional information you may require to process this request.

Thank you for your time and for considering my request during this difficult time. I look forward to hearing from you soon.

Sincerely,

[Your Signature]
[Your Printed Name]