

[Date]

[Medical Provider Name]
[Medical Facility Address]
[City, State, Zip Code]

RE: Statement of Financial Responsibility for Medical Treatment

To Whom It May Concern,

This letter serves as a formal statement that [Company Name] assumes full financial responsibility for the medical costs incurred by our employee, [Employee Full Name], for services related to [Specific Reason for Treatment/Injury Date].

Please provide the necessary medical treatment to the aforementioned employee. We request that all invoices and billing statements related to this matter be sent directly to our accounts department for processing:

[Company Name]
[Billing Department/Attention To]
[Mailing Address]
[Phone Number]
[Email Address]

The following details may be used for your records:

- Employee ID: [Employee ID Number]
- Date of Incident: [Date]
- Claim Number (if applicable): [Claim Number]

Please contact [Name of Contact Person] at [Phone Number] if you require further authorization or additional information regarding this account.

Sincerely,

[Signature]
[Printed Name]
[Job Title]
[Company Name]