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

[Date]

[Billing Department Name]
[Healthcare Provider/Hospital Name]
[Address]
[City, State, Zip Code]

Re: Financial Hardship Payment Plan Request
Patient Name: [Patient Name]
Account Number: [Account Number]
Total Balance Due: [Total Amount]

To Whom It May Concern,

I am writing to formally request a payment plan for the outstanding balance on the account mentioned above. Due to unexpected financial hardship, I am currently unable to pay the full balance in a single installment.

I value my relationship with [Healthcare Provider Name] and intend to fulfill my financial obligation. Based on my current monthly expenses and income, I am proposing a monthly payment of $[Amount] to be paid on the [Day] of each month until the balance is cleared.

I have attached [List documents, e.g., recent pay stubs or tax returns] to demonstrate my current financial situation. I would also like to request that any late fees or interest charges be waived during this period.

Please let me know if this proposal is acceptable or if there are specific financial assistance forms I need to complete. I look forward to your written confirmation of this arrangement.

Sincerely,

[Your Signature]

[Your Printed Name]