

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Approval of Emergency Treatment Hardship Discount

Account Number: [Account Number]

Date of Service: [Date of Emergency Treatment]

Dear [Patient Name],

We have received and reviewed your Financial Hardship Application regarding the emergency medical services provided to you on [Date of Service].

Based on the financial documentation provided, we are pleased to inform you that your request for a hardship discount has been approved. We understand that medical emergencies can create unexpected financial burdens, and we are committed to assisting our patients during these times.

The details of your adjusted balance are as follows:

- Original Total Charges: \$[Amount]
- Hardship Discount Applied ([Percentage]%) : - \$[Amount]
- **New Remaining Balance: \$[Amount]**

This discount applies specifically to the professional/facility fees associated with the emergency treatment date listed above. Please note that this adjustment does not cover services provided by third-party providers or outside laboratory testing not billed directly by this office.

Your updated statement reflecting this discount is attached. If you would like to set up a payment plan for the remaining balance, please contact our Billing Department at [Phone Number] or visit our online portal at [Website URL].

Sincerely,

[Name of Representative]

[Title]

[Organization Name]

[Billing Department Contact Information]