

[Date]

[Patient Full Name]

[Patient Address]

[City, State, Zip Code]

[Phone Number]

[Patient Account Number]

To: Billing Department

[Healthcare Provider/Clinic Name]

[Billing Address]

[City, State, Zip Code]

Subject: Request to Update Payment Method for Account #[Account Number]

Dear Billing Department,

I am writing to formally request an update to the payment method currently on file for my patient account. Please replace my existing payment information with the new details provided below for all future billings and recurring payments.

New Payment Information:

- Name on Card/Account: [Name]
- Type of Card: [e.g., Visa, Mastercard, HSA, Debit]
- Last Four Digits of Card: [Last 4 Digits]
- Expiration Date: [MM/YYYY]

Please ensure that the previous payment method is removed and that this new method is applied to my account effective immediately. If you require me to log into a secure portal or call to provide the full card number for security reasons, please let me know at your earliest convenience.

Please send a confirmation once this update has been processed.

Thank you for your assistance.

Sincerely,

[Signature]

[Printed Name]