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

[Date]

[Debt Collector Name]
[Debt Collector Address]
[City, State, Zip Code]

RE: Notice of Representation and Request for Debt Verification

Account Holder: [Patient Full Name]
Account Number: [Reference Number]
Creditor: [Original Medical Provider Name]

To Whom It May Concern,

Please be advised that this office represents [Patient Full Name] regarding the above-referenced medical debt. All future communications regarding this matter must be directed to our office at the address provided above. Do not contact our client directly.

Pursuant to the Fair Debt Collection Practices Act (FDCPA), 15 U.S.C. $ 1692g, this letter serves as a formal request for verification and validation of the alleged debt. Please provide the following information:

- Evidence of the legal authorization to collect this debt.
- A complete itemized statement of the services rendered, including dates of service and CPT codes.
- Verification that the amount requested reflects any insurance adjustments or payments.
- Confirmation that the patient was provided with any applicable financial assistance or "charity care" information required by law.
- Proof that the statute of limitations for collecting this medical debt has not expired.

If you fail to provide the requested validation within thirty (30) days of receipt of this notice, you must cease all collection activities and remove any derogatory information reported to credit bureaus regarding this account.

Sincerely,

[Your Signature]

[Your Printed Name/Title]