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

[Date]

[Name of Debt Collector/Agency]
[Address of Agency]
[City, State, Zip Code]

Re: Account Number [Insert Account Number]
Reference Number [Insert Reference Number, if applicable]

Dear [Name of Debt Collector or Debt Collection Agency],

I am writing this letter in response to your notice dated [Date of notice received] regarding an alleged debt for medical services rendered. This is not a refusal to pay, but a formal request for validation of this debt pursuant to the Fair Debt Collection Practices Act (FDCPA), 15 U.S.C. $ 1692g.

I formally request that you provide the following information to verify the validity of this debt:

- The name and address of the original medical provider.
- The date(s) of service for which this debt is claimed.
- An itemized statement of the services rendered and the costs associated with each.
- A copy of any document bearing my signature in which I agreed to pay the medical provider.
- Verification that the statute of limitations for collecting this debt has not expired.
- Documentation showing that your agency is licensed to collect debts in my state.

Please note that if this debt involves information protected by the Health Insurance Portability and Accountability Act (HIPAA), I do not waive any of my privacy rights. I request that you provide only the minimum necessary information required to validate the debt without violating medical privacy laws.

Under the FDCPA, you must cease all collection efforts until you provide the requested validation information. Furthermore, if you have reported this debt to any credit reporting agencies, please ensure it is marked as "disputed." Failure to do so may be a violation of the Fair Credit Reporting Act (FCRA).

I look forward to receiving the requested documentation within 30 days of your receipt of this letter.

Sincerely,

[Your Signature]

[Your Printed Name]