

Date: [Date]

To: [Medical Provider Name/Facility Name]

Address: [Provider Address]

City, State, Zip: [Provider City, State, Zip]

RE: Letter of Protection

Patient Name: [Patient Name]

Date of Loss/Injury: [Date of Incident]

Claim Number: [Insurance Claim Number, if applicable]

To Whom It May Concern,

This office represents [Patient Name] regarding injuries sustained in the above-referenced incident. Our client is seeking pain management evaluation and treatment from your facility.

Please accept this Letter of Protection as a formal agreement that the outstanding balance for medical services rendered to our client will be paid directly to your office from any settlement, judgment, or recovery obtained in this legal matter.

By accepting this letter, you agree to withhold any collection efforts against our client until the legal claim is resolved. We agree to notify your office immediately upon the conclusion of this case and to ensure your lien is satisfied before any funds are disbursed to the client.

Please provide us with copies of all medical records and itemized billing statements as treatment progresses.

Sincerely,

[Attorney Signature]

[Attorney Printed Name]

[Law Firm Name]

Acknowledge and Agreed:

[Medical Provider Representative Signature]

Date: _____