

DATE: [Date]

TO:

[Hospital Name]

[Billing Department Address]

[City, State, Zip Code]

RE: [Patient Full Name]

DATE OF INCIDENT: [Date of Accident/Injury]

PATIENT ACCOUNT #: [Account Number, if known]

To Whom It May Concern,

Please be advised that this office represents [Patient Name] regarding injuries sustained in an incident on [Date of Incident].

This letter shall serve as a Letter of Protection (LOP) regarding the medical services and facility charges provided to our client by [Hospital Name]. We request that you refrain from pursuing active collection efforts or reporting this account to credit agencies while our client's legal claim is pending.

In consideration for your agreement to defer payment, we hereby agree to protect your outstanding balance and will pay the reasonable and necessary medical charges directly from any settlement, judgment, or recovery obtained on behalf of our client. Payment will be issued prior to the disbursement of any net proceeds to the client.

Please note that this letter does not guarantee a specific recovery amount, nor does it create a personal liability for this law firm to pay the medical bills in the event there is no recovery. However, it is an agreement to withhold and pay your facility from any funds received.

Please acknowledge your acceptance of this Letter of Protection by signing below and returning a copy to our office. Please also provide a current itemized statement of charges for our records.

Sincerely,

[Attorney Name]

[Law Firm Name]

[Phone Number]

ACKNOWLEDGED AND AGREED:

By: _____
Authorized Representative for [Hospital Name]

Date: _____