

PHARMACY SERVICES LETTER OF PROTECTION

Date: [Date]

To: [Pharmacy Name]
[Pharmacy Address]
[City, State, Zip Code]

Re: [Patient Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]
Law Firm File Number: [Case Number]

To Whom It May Concern:

Please be advised that this office represents the above-named patient in a legal claim for personal injuries sustained on the date mentioned above.

This Letter of Protection is issued to guarantee the payment of pharmaceutical charges incurred by our client for medications related to the aforementioned incident. In exchange for your agreement to provide medications on credit, we agree to withhold and pay the outstanding balance due to your pharmacy directly from any settlement, judgment, or recovery obtained on behalf of the patient.

Please note the following conditions:

- Payment will be made directly to the pharmacy upon the successful resolution and receipt of funds from the case.
- Our firm will notify you once the case has been resolved.
- The patient remains ultimately responsible for the debt should there be no recovery or if the recovery is insufficient to cover all medical expenses.

Please provide us with regular itemized statements of the charges incurred. We request that you do not send this account to a collection agency while the legal matter is pending.

Please acknowledge your acceptance of this agreement by signing below and returning a copy to our office.

Sincerely,

[Attorney Signature]
[Attorney Name]
[Law Firm Name]

ACKNOWLEDGMENT AND ACCEPTANCE:

I, the undersigned, agree to the terms of this Letter of Protection.

[Pharmacy Representative Signature]

[Date]