DATE: [Date]

TO: [Name of Surgeon/Medical Provider]
FACILITY: [Name of Surgical Center/Hospital]
ADDRESS: [Provider Address]

RE: [Patient Name]
DOB: [Patient Date of Birth]
DOI: [Date of Incident/Injury]
CLAIM NUMBER: [Insurance Claim Number]

To Whom It May Concern,

This office represents the above-named patient in a legal claim for personal injuries sustained on the date referenced above. It is our understanding that the patient requires surgical intervention for injuries related to this incident.

This letter shall serve as a **Letter of Protection** regarding the medical expenses for the following upcoming procedure: [Type of Surgery/Procedure].

By accepting this Letter of Protection, you agree to provide the necessary surgical services and hold any bills for said services in abeyance until the conclusion of the patient's legal claim. In exchange, this office agrees to protect your outstanding medical lien and process payment directly to your facility/office from any settlement, judgment, or recovery obtained on behalf of the patient.

Please note that this letter does not guarantee the recovery of any specific amount, but it does ensure that your bills will be paid from the proceeds of the case prior to any distribution to the client. This office will not release any settlement funds to the client without first addressing your outstanding balance.

Please sign and return a copy of this letter to acknowledge your acceptance of these terms. Upon completion of the procedure, please provide this office with the itemized billing statement and operative reports.

Sincerely,

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

ACKNOWLEDGED AND AGREED TO BY PROVIDER:

Signature: ______________________________
Date: __________________________________