[Date]

[Provider Name/Facility Name]
[Provider Address]
[City, State, Zip Code]

RE: Letter of Protection
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]
Our File Number: [Internal File Number]

To Whom It May Concern,

This office represents the above-named client regarding injuries sustained in the incident referenced above. This letter serves as a formal Letter of Protection (LOP) regarding the medical services and pain management treatment provided to our client.

We hereby request that you provide all necessary medical evaluations, diagnostic testing, and pain management treatments for our client on a protected lien basis. In consideration for your agreement to provide these services without immediate payment, [Law Firm Name] agrees to withhold and pay from any settlement or judgment proceeds such sums as may be due and owing to your facility for medical services rendered to this client.

Please note the following terms:

- This letter does not guarantee payment from this firm unless a recovery is made on behalf of the client.
- The client remains ultimately responsible for the payment of all medical bills regardless of the outcome of the legal claim.
- We request that you provide us with copies of all medical records and itemized billing statements immediately following each visit or procedure.

Please acknowledge your acceptance of this Letter of Protection by signing below and returning a copy to our office via [Email/Fax].

Sincerely,

[Attorney Name]
[Law Firm Name]

ACKNOWLEDGED AND AGREED TO:

By: _____
Authorized Representative for [Provider Name]

Date: _____