[Date]

[Pharmacy Name or Medical Provider Name]
[Accounting/Billing Department]
[Street Address]
[City, State, Zip Code]

RE: Payment Enclosure per Letter of Protection

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Account/Invoice Number: [Number]
Date of Incident: [Date]

To Whom It May Concern,

Enclosed please find a check in the amount of $[Amount] representing payment for medication and/or medical supplies provided to the above-referenced patient.

This payment is being issued following the resolution of the patient's personal injury claim, in accordance with the Letter of Protection (LOP) previously filed with your office. This amount constitutes [Full Payment / Partial Payment] for the outstanding balance related to the treatment of injuries sustained on the date of incident listed above.

Please apply these funds to the patient's account immediately. We request that you provide a final statement showing a zero balance or an updated ledger reflecting this credit for our records.

If you have any questions regarding this payment, please contact our office at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Law Firm Name or Payer Name]
[Phone Number]

Enclosure: Check #[Number]