Date: [Insert Date]

To: [Insert Pharmacy Name or Provider]
Address: [Insert Pharmacy Address]
City, State, Zip: [Insert City, State, Zip]

RE: Final Disbursement of Pharmacy Charges
Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Account/Invoice Number: [Insert Number]

Dear Billing Department,

Enclosed please find a check in the amount of $[Insert Amount]. This payment represents the final disbursement and full settlement for pharmacy services provided to the above-referenced patient regarding the date(s) of service from [Start Date] to [End Date].

By accepting and depositing this check, you acknowledge that the balance for this account is paid in full. No further payments are due from the patient or the representative for these specific charges.

Please update your records to show a zero balance for this account.

If you have any questions, please contact me at [Insert Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title/Organization]

Enclosure: Check No. [Insert Check Number]