

[Sender Name/Law Firm]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Conditional Letter of Protection

Patient Name: [Patient Name]
Date of Incident: [Date of Accident]
Claim Number: [Claim Number, if available]

To Whom It May Concern,

Please be advised that this office represents the above-named patient regarding injuries sustained in an incident on the date referenced above. Liability for this matter is currently pending a formal determination by the insurance carrier/responsible party.

In consideration of your agreement to provide medical treatment to our client on a credit basis, this letter serves as a **Conditional Letter of Protection**. This office agrees to withhold and pay directly to your facility any outstanding balances for services related to this incident from any settlement, judgment, or recovery received on behalf of the client, subject to the following conditions:

- Liability is formally accepted by the defendant or their insurance carrier.
- A recovery or settlement is actually obtained by this office on behalf of the client.
- The medical charges are reasonable, necessary, and directly related to the incident in question.

This letter does not constitute a guarantee of payment if no recovery is made. In the event that no recovery is obtained, or if liability is denied, the patient remains personally responsible for the payment of all medical bills incurred.

Please provide this office with copies of all medical records and itemized billing statements as they become available. We request that you do not refer this account to a collection agency while this legal matter is pending.

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

Sincerely,

[Attorney Signature]
[Printed Name]

Acknowledge and Agreed:

Medical Provider Representative Date