Date: [Date]

TO: [Medical Provider Name]
ADDRESS: [Medical Provider Address]
RE: [Patient/Client Name]
DATE OF INCIDENT: [Date of Accident/Injury]
CLAIM NUMBER: [Insurance Claim Number]

To Whom It May Concern,

Our office represents the above-named client regarding personal injuries sustained in the aforementioned incident. This letter serves as a **Conditional Letter of Protection (LOP)** concerning the medical services provided by your facility.

Our firm agrees to protect your outstanding medical bills for services related to this incident, to be paid directly from any settlement, judgment, or recovery obtained on behalf of the client. However, this protection is strictly **conditional** upon the following:

1. **Disclosure of Policy Limits:** This LOP is contingent upon the formal disclosure of the third-party insurance carrier's policy limits. If the available policy limits are insufficient to cover the total value of all medical liens and legal costs, this LOP may be subject to renegotiation or pro-rata distribution.
2. **Final Settlement Approval:** Payment is predicated upon a successful recovery of funds. This letter does not guarantee full payment if the total recovery is limited by liability disputes or inadequate insurance coverage.
3. **Documentation:** Please provide our office with all itemized billing statements and medical records associated with the treatment of our client.

By accepting this letter, you agree to look solely to the proceeds of the client's legal claim for payment and to refrain from any collection efforts against the client personally while the legal matter is pending.

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

Sincerely,

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

ACCEPTED AND AGREED TO:

By: _____
[Authorized Provider Representative Name/Title]
Date: _____