

Date: [Date]

To: [Medical Provider Name/Facility]

Address: [Provider Address]

City, State, Zip: [City, State, Zip]

RE: [Patient Name]

Date of Incident: [Date of Incident]

Claim Number: [Claim Number, if applicable]

Dear [Medical Provider Name or Billing Department],

This office represents [Patient Name] regarding injuries sustained in the above-referenced incident. Our client is seeking medical treatment at your facility for these injuries.

Please accept this **Conditional Letter of Protection**. My client authorizes and directs this office to pay you directly for medical services rendered out of any settlement or judgment obtained in this matter. By providing treatment under this agreement, you agree to withhold any collection efforts or reporting to credit agencies against the client pending the resolution of their legal claim.

Pro Rata Reduction Provision:

This Letter of Protection is expressly conditional. In the event that the total recovery (net of attorney fees and legal costs) is insufficient to satisfy all outstanding medical liens and subrogation interests in full, you agree to accept a **pro rata reduction** of your total bill. Under such circumstances, all medical providers and lienholders will share the available net proceeds proportionally based on their respective balances.

This agreement does not guarantee full payment but ensures that you will receive a fair and equitable distribution of available funds. If no recovery is made, the patient remains personally responsible for the balance of your bill.

Please acknowledge your acceptance of these terms by signing below and returning a copy to our office along with the patient's initial medical records and billing statements.

Sincerely,

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGED AND AGREED:

Authorized Signature for Medical Provider

Date

[Patient/Client Signature]