

**Date:** [Date]

**To:** [Medical Provider Name]

**Address:** [Provider Address]

**City, State, Zip:** [Provider City, State, Zip]

**RE:** [Patient Name]

**Date of Incident:** [Date of Accident/Injury]

**Claim Number:** [Insurance Claim Number, if applicable]

Dear [Contact Name or Billing Department],

This office represents [Patient Name] regarding injuries sustained in the above-referenced matter. Please accept this Letter of Protection (LOP) as a formal agreement regarding the payment of medical services rendered to our client.

**Maximum Authorized Balance:**

The total amount authorized under this Letter of Protection shall not exceed **\$(Insert Dollar Amount)** without prior written consent from this office. Any charges incurred beyond this maximum authorized balance will be the sole responsibility of the patient and are not covered by this specific guarantee of payment from settlement proceeds.

In consideration for your continued medical treatment of our client, we agree to withhold and pay such sums as may be due and owing to your facility for services rendered directly from any settlement, judgment, or verdict received. Payment will be issued at the time of the final distribution of funds.

Please provide this office with copies of all medical records and itemized billing statements as they become available. By signing below, you acknowledge and agree to the maximum authorized limit stated herein.

Sincerely,

[Attorney Signature]

[Attorney Name]

[Law Firm Name]

**Acknowledged and Agreed:**

\_\_\_\_\_  
[Medical Provider Representative Name/Title]

Date: \_\_\_\_\_