

[Date]

[Medical Provider Name]

[Address]

[City, State, Zip Code]

RE: Letter of Protection (Specified Limit)

Patient Name: [Patient Name]

Date of Loss/Injury: [Date of Incident]

Claim Number: [Claim Number, if applicable]

Dear [Medical Provider Name or Billing Department],

This office represents [Patient Name] regarding personal injury claims arising from the above-referenced incident. Our client is seeking medical treatment from your facility for injuries sustained in this matter.

By this letter, we acknowledge a Letter of Protection for your services, subject to a specified maximum limit. We agree to protect your medical bills for services rendered to our client, provided that the total amount protected under this agreement shall not exceed **[\$Insert Dollar Amount]**.

This protection is contingent upon the successful recovery of a settlement, judgment, or verdict in favor of our client. Payment will be made directly from the proceeds of any such recovery at the time of final disbursement. If no recovery is made, or if the recovery is insufficient to cover all legal costs and liens, the patient remains personally responsible for the balance of your bill.

Please provide our office with copies of all medical records and itemized billing statements as they become available. Upon the conclusion of this case, we will contact your office to verify the final balance within the agreed-upon limit.

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]

Acknowledgment and Acceptance:

Signature of Provider: _____

Date: _____