[Date]

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

RE: Pre-Approved Maximum Balance Letter of Protection

Patient Name: [Patient Name]
Date of Loss: [Date of Incident]
Claim Number: [Claim Number]

To Whom It May Concern,

Please be advised that this office represents the above-named client regarding injuries sustained in the aforementioned incident. This letter serves as a formal Letter of Protection (LOP) to facilitate necessary medical treatment for our client.

Our firm agrees to protect your medical charges out of any settlement or judgment reached in this matter, subject to the following **Maximum Pre-Approved Balance**:

Approved Limit: $[Insert Dollar Amount]

By accepting this letter and providing treatment, you agree to the following terms:

- The total balance for services rendered shall not exceed the pre-approved limit stated above without prior written authorization from this office.
- Payment will be made directly to your office upon the final resolution of the legal claim.
- The client remains ultimately responsible for the bill should the legal recovery be insufficient to cover the costs.
- You will provide this office with copies of all medical records and itemized billing statements immediately following the conclusion of treatment.

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]

Provider Acceptance:

Authorized Signature: _____ Date: _____