

Date: [Date]

To: [Provider Name/Medical Facility]

Address: [Provider Address]

Attn: Billing Department

RE: Letter of Protection and Maximum Allowable Balance Agreement

Patient Name: [Patient Name]

Date of Birth: [DOB]

Date of Incident: [Date of Accident]

Claim Number: [Claim Number, if available]

Dear Billing Manager,

This office represents the above-named patient regarding injuries sustained in the aforementioned incident. This letter serves as a formal Letter of Protection (LOP) to guarantee payment of medical services rendered to our client from any future settlement, judgment, or verdict.

Maximum Allowable Balance Agreement:

Please be advised that this Letter of Protection is subject to a Maximum Allowable Balance. Our client agrees to be responsible for medical charges up to, but not exceeding, the total amount of \$[Dollar Amount]. Any charges incurred beyond this maximum allowable balance must be pre-authorized in writing by this office to be covered under this LOP.

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

- You will withhold all collection efforts against the patient pending the resolution of their legal claim.
- Payment will be made directly to your facility from the proceeds of the settlement or judgment.
- The total recovery for services rendered shall not exceed the specified Maximum Allowable Balance unless modified in writing.

Please provide this office with copies of all medical records and itemized billing statements immediately following the conclusion of treatment. If this agreement is not acceptable, please notify our office in writing within five (5) business days.

Sincerely,

[Your Name/Attorney Name]

[Law Firm Name]

[Phone Number]

Acknowledgment and Acceptance:

[Provider Representative Signature]

[Date]