[Current Date]

[Provider Name or Medical Facility]
[Billing Department]
[Street Address]
[City, State, Zip Code]

RE: Payment for Services under Letter of Protection
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident/Injury]
Account/Invoice Number: [Reference Number]

To Whom It May Concern,

Enclosed please find a check in the amount of $[Amount] as full and final payment for the medical services provided to the above-referenced patient. This payment is being issued following the resolution of the patient's legal claim, which was previously subject to a Letter of Protection (LOP) issued by this office.

Payment Details:
Check Number: [Check Number]
Check Amount: $[Amount]

Please apply these funds to the patient's outstanding balance. By accepting and cashing this check, you acknowledge that the account is paid in full and that all liens or claims against the patient's legal recovery regarding this matter are hereby satisfied and released.

Kindly update your records to show a zero balance and cease any further billing or collection efforts for this account.

If you have any questions, please contact our office at [Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Law Firm or Company Name]
[Phone Number]

Enclosure: Check #[Check Number]