[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Hospital or Clinic Name]
[Billing Department Address]
[City, State, Zip Code]

RE: Request for Medical Bill Reduction
Patient Name: [Patient Name]
Account Number: [Account Number]
Statement Date: [Date of Statement]
Total Balance: $[Total Amount]

To the Billing Department,

I am writing to formally request a reduction of the current balance owed on the account mentioned above. Due to unforeseen financial hardship, I am unable to pay the full amount at this time.

I value the medical care I received, but the current bill exceeds my financial capacity. I am requesting that you review my account for any available discounts, financial assistance programs, or a one-time settlement offer. Specifically, I am asking if you can reduce the total balance to $[Amount You Can Pay] or apply a sliding scale discount based on my income.

I am also open to discussing a monthly payment plan that fits my budget if a total reduction is not possible. I have attached [mention any documents like pay stubs or tax returns, if applicable] to demonstrate my current financial situation.

Please let me know what options are available to help resolve this balance. I look forward to hearing from you soon. Thank you for your time and understanding.

Sincerely,

[Your Signature]
[Your Printed Name]