[Your Name/Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email]

[Date]

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

RE: Pro Rata Settlement Distribution / Letter of Protection
Patient Name: [Patient Name]
Date of Service: [Date of Service]
Account Number: [Account Number]
Total Balance: [Total Amount Owed]

To Whom It May Concern,

This office represents [Client Name] regarding a personal injury claim arising from an incident on [Date of Accident].

We are currently in the process of finalizing a settlement for this matter. Unfortunately, the available insurance policy limits and total settlement funds are insufficient to satisfy all outstanding medical liens and legal costs in full. To achieve a fair resolution for all parties involved, we are requesting a pro rata reduction of your outstanding balance.

Based on the total recovery and the proportional distribution among all lienholders, we are requesting that you accept **$[Proposed Reduced Amount]** as full and final satisfaction of this account. This represents [Percentage]% of your total bill.

Please review this request and indicate your acceptance by signing below and returning this letter to our office via mail or email at [Email Address]. Upon receipt of the signed agreement and the settlement funds, we will issue payment immediately.

Thank you for your cooperation in resolving this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

ACCEPTANCE OF PRO RATA REDUCTION:

The undersigned agrees to accept $[Proposed Reduced Amount] as full and final payment for account number [Account Number].

Signature: _____ Date: _____

Printed Name/Title: _____