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

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

RE: SETTLEMENT REQUEST AND LIEN REDUCTION
Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident]
Account/Invoice Number: [Account Number]

Dear Billing Department,

This office represents [Patient Name] regarding injuries sustained in the above-referenced incident. As you are aware, your services were provided under a Letter of Protection (LOP).

We are pleased to inform you that we have reached a tentative settlement for this personal injury claim. However, the total settlement funds are insufficient to cover all outstanding medical liens, legal fees, and costs while still providing a recovery for the client. The total gross settlement is $[Total Settlement Amount].

Your current outstanding balance is reported as $[Current Balance].

In the interest of a global resolution of all claims, we are requesting that you accept a reduced payment of **$[Proposed Reduction Amount]** as full and final satisfaction of this lien. This reduction is necessary to finalize the settlement and ensure the client receives a fair portion of the recovery for their pain and suffering.

Please review this request and indicate your acceptance by signing below and returning this letter to our office via fax at [Fax Number] or email at [Email Address]. Once we receive written confirmation and the settlement funds are cleared, we will issue payment immediately.

Thank you for your cooperation and for the care provided to our client.

Sincerely,

[Your Name/Signature]

ACCEPTANCE OF REDUCED LIEN AMOUNT:

The undersigned agrees to accept the sum of $[Proposed Reduction Amount] as full and final payment for all services rendered to [Patient Name] for the date of incident [Date].

By: _____
Title: _____
Date: _____