[Date]

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

RE: Request for Reduction of Medical Lien / Protection Balance

Patient Name: [Client Full Name]
Date of Loss: [Date of Incident]
Account Number: [Provider Account Number]

Dear Billing Department,

Our office represents the above-named client regarding their personal injury claim. We have reached a final settlement in this matter. However, the total settlement funds available are insufficient to cover all outstanding medical liens, legal fees, and costs while providing a reasonable recovery for the client.

The current balance reflected in your records is $[Current Balance]. We are respectfully requesting that you accept a reduced payment of **$[Proposed Reduced Amount]** as full and final satisfaction of this account.

This reduction is necessary to finalize the distribution of funds and ensure the client receives a portion of the settlement to cover their ongoing needs and pain and suffering. By accepting this amount, you will receive immediate payment and avoid further collection efforts.

Please confirm your acceptance of this reduction by signing below and returning this letter to our office via email at [Email Address] or fax at [Fax Number]. Upon receipt of your confirmation, we will issue a check for the agreed-upon amount.

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

Sincerely,

[Attorney Name]
[Law Firm Name]

Acceptance of Reduced Payment:

The undersigned agrees to accept $[Proposed Reduced Amount] as full and final payment for the account listed above.

Signature: _____ Date: _____

Printed Name/Title: _____