

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

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

RE: NOTICE OF LETTER OF PROTECTION
Patient Name: [Patient Full Name]
Date of Incident: [Date of Accident/Injury]
Claim Number: [Insurance Claim Number, if applicable]

To Whom It May Concern,

Please be advised that this office represents [Patient Name] regarding injuries sustained in the above-referenced incident. Our client is currently seeking medical treatment at your facility for these injuries.

By way of this letter, we are issuing a formal Letter of Protection (LOP). We agree to protect your outstanding medical bills related to this matter from any settlement, judgment, or verdict received by the client. We request that you withhold further collection efforts against the patient personally pending the outcome of their legal claim.

Payment will be made directly to your office out of the proceeds of any recovery. Please note that this letter does not guarantee the sufficiency of the settlement to cover all costs, nor does it waive the patient's ultimate responsibility for the bill should there be no recovery.

Please provide our office with copies of all medical records and itemized billing statements for the treatment provided to date. We also request that you notify us immediately if there are any significant changes in the treatment plan.

Kindly acknowledge receipt of this notice by signing below and returning a copy to our office.

Sincerely,

[Your Signature]
[Your Printed Name]

ACKNOWLEDGMENT

The undersigned medical provider hereby acknowledges receipt of this Letter of Protection and agrees to the terms stated above.

Signature: _____ Date: _____