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

[Date]

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

Re: Request for Balance Reduction
Patient Name: [Patient Name]
Account Number: [Account Number]
Total Current Balance: [Amount]

To Whom It May Concern,

I am writing to formally request a reduction of the current balance owed on the account referenced above. I recently received the billing statement for services provided on [Date of Service].

Due to unexpected financial hardship caused by [briefly mention reason, e.g., loss of income, high medical expenses, or lack of insurance coverage], I am unable to pay the full balance of [Amount].

I am committed to resolving this debt and would like to offer a one-time, lump-sum payment of [Amount you can afford] as a settlement in full for this account. If a settlement is not possible, I request that you consider applying any available financial assistance, charity care discounts, or a long-term interest-free payment plan that fits my current budget.

Please let me know if there are specific financial assistance forms I need to complete or if you require documentation regarding my financial situation.

Thank you for your time and for considering my request. I look forward to hearing from you soon to resolve this matter.

Sincerely,

[Your Signature]

[Your Printed Name]