Date: [Date]

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

RE: Compromised Settlement and Payment Distribution

Patient Name: [Patient Full Name]
Date of Loss/Injury: [Date]
Account/Reference Number: [Account Number]

Dear Billing Department,

As you are aware, this office represented the above-named patient regarding their personal injury claim. Our records indicate that your facility provided medical services under a Letter of Protection (LOP).

Please be advised that this case has reached a final settlement. Due to the limited nature of the recovery funds and the total amount of outstanding liens, it was necessary to compromise all medical bills to reach a resolution.

Pursuant to our previous discussions/agreement, we have finalized the pro-rata distribution of the settlement proceeds. Please find enclosed a check in the amount of **$[Amount]** as full and final payment for the services rendered to the patient for the above-referenced date of loss.

Final Agreement Terms:

- Original Bill Amount: $[Original Amount]
- Negotiated Compromise Amount: $[Compromise Amount]
- Payment Enclosed: $[Amount]

By accepting and negotiating this payment, you agree that the patient's account is now paid in full and that any remaining balance is waived. Please update your records to show a zero balance and ensure that no further collection efforts are pursued against the patient.

Thank you for your cooperation and for providing care to our client.

Sincerely,

[Your Name/Firm Name]
[Your Phone Number]

Enclosure: Payment Check #[Check Number]