[Date]

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

RE: Settlement Disbursement / Policy Limits Exhausted

Patient Name: [Patient Name]
Date of Accident: [Date of Accident]
Our File Number: [File Number]

Dear Billing Department,

Our office represents the above-named client regarding injuries sustained in the referenced accident. We previously issued a Letter of Protection (LOP) regarding your outstanding medical bills.

Please be advised that we have resolved this claim. However, the total available insurance policy limits were exhausted. As the recovery was insufficient to satisfy all outstanding medical liens and legal costs in full, we have performed a pro-rata distribution of the available funds.

Enclosed please find a check in the amount of $[Amount] as payment toward the patient's outstanding balance of $[Total Balance].

By accepting and negotiating this check, you agree to accept this amount as full and final satisfaction of any and all claims, liens, or bills related to the services provided to our client for this matter. This payment releases our client and this firm from any further liability under the Letter of Protection.

Please update your records accordingly to show a zero balance for this patient.

Thank you for your cooperation.

Sincerely,

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

Enclosure: Check #[Check Number]