[Date]

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

Re: Payment of Outstanding Medical Charges
Patient: [Client Name]
Date of Accident: [Date of Incident]
Claim Number: [Claim Number]

Dear Billing Department,

Enclosed please find a check in the amount of $[Amount] representing payment for the medical services provided to our client, [Client Name], in relation to the above-referenced matter.

This payment is being issued pursuant to the Letter of Protection (LOP) previously held by your office. Please note that this disbursement has been reviewed and authorized by the client as part of the final settlement of their legal claim.

Acceptance and negotiation of this check constitutes full and final satisfaction of all outstanding balances, liens, or claims your facility may have against [Client Name] or this firm regarding the treatment provided for the aforementioned accident date.

Please update your records to reflect that this account is now paid in full.

Sincerely,

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

Enclosure: Check No. [Check Number]