**Date:** [Date]

**TO:** [Medical Provider Name/Facility]
**ATTN:** Billing Department / Records Department
**ADDRESS:** [Provider Address]
**CITY, STATE, ZIP:** [City, State, Zip]

**RE: Notice of Revocation of Letter of Protection (LOP)**
**Patient Name:** [Patient Full Name]
**Date of Birth:** [Date of Birth]
**Date of Incident:** [Date of Incident]
**Account/Patient ID:** [Account Number]

To Whom It May Concern,

Please be advised that the Letter of Protection (LOP) previously issued to your facility regarding the medical treatment of the above-named patient is hereby **REVOKED** and rescinded, effective immediately.

This revocation serves as formal notice that [Law Firm Name/Patient Name] will no longer guarantee payment from any future legal settlement, judgment, or recovery related to this claim. You are no longer authorized to rely upon the LOP for the security of payment for services rendered.

We request that you immediately pursue alternative payment methods for any outstanding balances, including but not limited to:

- Submitting claims to the patient's primary health insurance provider;
- Billing the patient's Personal Injury Protection (PIP) or Medical Payments (MedPay) coverage;
- Directly billing the patient.

Please update your records to reflect that this office is no longer representing the patient in a capacity involving an LOP agreement with your facility. If there are any remaining balances, please provide a final itemized statement to the patient at their address on file.

Sincerely,

[Your Signature]
[Printed Name]
[Title/Company Name]
[Phone Number]

CC: [Patient Name]