

[Date]

[Name of Surgical Facility Administrator]

[Name of Surgical Facility]

[Address]

[City, State, Zip Code]

RE: Letter of Protection

Patient Name: [Patient Full Name]

Date of Incident: [Date of Accident/Injury]

Date of Service: [Date of Surgery]

Claim Number: [Insurance Claim Number]

To the Billing Department:

I represent [Patient Name] in a legal claim for personal injuries sustained on [Date of Incident]. My client requires surgical services at your facility; however, your facility is currently an out-of-network provider under my client's insurance plan, or my client is currently uninsured for this procedure.

This letter serves as a Letter of Protection (LOP) regarding the medical expenses incurred by my client at your facility. In consideration of your agreement to provide medical services and stay all collection efforts against my client pending the resolution of their legal claim, I agree to withhold and pay directly to your facility such sums as may be due and owing for medical services rendered from any settlement, judgment, or verdict received.

Please note the following terms:

- This LOP applies specifically to the facility fees and associated costs for the surgery scheduled on [Date of Service].
- Payment will be made directly to your facility out of the proceeds of the recovery at the time of final settlement or distribution of funds.
- My client remains ultimately responsible for the total cost of services rendered should the legal claim result in no recovery.

Please acknowledge your acceptance of this Letter of Protection by signing below and returning a copy to my office. We also request that you provide a copy of the final itemized billing statement once the procedure is complete.

Sincerely,

[Attorney Name]

[Law Firm Name]

ACKNOWLEDGED AND AGREED:

Authorized Representative of Surgical Facility

Date