[Your Name/Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Provider Name/Facility Name]
[Provider Address]
[City, State, Zip Code]

RE: Letter of Protection

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Incident: [Date of Accident]
Claim Number: [Insurance Claim Number]

Dear [Provider Name or Billing Department],

Please be advised that this office represents the above-named patient in a legal claim for personal injuries sustained in the incident referenced above. This letter serves as a formal Letter of Protection (LOP) regarding the medical services provided to our client.

We understand that your facility is an out-of-network provider for our client's insurance. In consideration for your continued treatment and/or your agreement to withhold immediate collection efforts, our client hereby authorizes and directs this office to pay any outstanding balances for medical services rendered directly from the proceeds of any settlement, judgment, or verdict obtained in this matter.

By accepting this letter, you agree to:

- Await payment until the conclusion of the legal claim.
- Cease any formal collection actions or credit reporting against the patient during the pendency of this claim.
- Provide our office with copies of updated medical records and itemized billing statements upon request.

Please note that this letter does not guarantee the sufficiency of the settlement funds to cover all costs, but it ensures that your bill will be protected and paid as a priority from the net recovery. In the event there is no recovery, the patient remains personally responsible for the medical charges incurred.

Please acknowledge your acceptance of this agreement by signing below and returning a copy to our office.

Sincerely,

_____
[Attorney Signature]

Acknowledgment and Agreement by Patient:

I hereby authorize my attorney to pay the above provider directly from the proceeds of my legal recovery.

_____
[Patient Signature]

Acknowledgment and Agreement by Provider:

_____
[Provider/Authorized Representative Signature]