[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Request for Reduction of Medical Lien / Letter of Protection
Patient Name: [Your Name]
Account Number: [Account Number]
Date of Service: [Date of Service]
Total Amount Billed: $[Total Amount]

To Whom It May Concern,

I am writing to formally request a reduction of the outstanding balance owed to your facility under the Letter of Protection (LOP) issued for my personal injury case. My legal claim has recently reached a final settlement; however, the total recovery was significantly lower than anticipated.

After deducting attorney fees, litigation costs, and other mandatory medical liens, the remaining funds are insufficient to cover all outstanding medical bills in full. I am currently facing extreme financial hardship due to [mention brief reason, e.g., lost wages, permanent disability, or high cost of living].

In an effort to resolve this debt immediately and avoid further collection actions, I am proposing a one-time, final payment of **$[Offer Amount]** as full and final satisfaction of this account. This represents [Percentage]% of the total billed amount.

If you agree to this reduction, please provide a written confirmation or an updated final invoice reflecting this balance. Upon receipt, I will instruct my attorney to issue payment immediately from the settlement proceeds.

Thank you for your time, your medical care, and your willingness to work with me during this difficult period.

Sincerely,

[Your Signature]
[Your Printed Name]

cc: [Attorney Name, if applicable]