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

[Date]

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

RE: Notice of Proposed Pro Rata Settlement Distribution

Patient Name: [Patient Name]
Date of Loss: [Date of Incident]
Account/Claim Number: [Account Number]

To Whom It May Concern,

Our office represents [Patient Name] regarding the personal injury matter referenced above. A settlement has been reached in this case; however, the total recovery is insufficient to satisfy all outstanding medical liens and legal obligations in full.

As we previously issued a Letter of Protection (LOP) to your facility, we are committed to ensuring a fair and equitable distribution of the available funds. We are proposing a **pro rata distribution** among all medical providers based on the percentage of total medical debt owed.

The breakdown of the proposed distribution is as follows:

- **Total Settlement Amount:** $[Amount]
- **Total Medical Bills Outstanding:** $[Total Debt]
- **Pro Rata Percentage:** [Percentage]%
- **Proposed Payment to Your Facility:** $[Proposed Amount]

By accepting this payment, you agree to accept the amount of $[Proposed Amount] as **full and final satisfaction** of the balance owed for the dates of service related to this claim. You further agree to waive any remaining balance and to release any liens associated with this account.

Please indicate your acceptance of this pro rata proposal by signing below and returning this letter to our office via [Email/Fax]. Once received, we will issue the check immediately.

Sincerely,

[Your Signature]

[Your Printed Name]

Acceptance of Pro Rata Distribution:

The undersigned hereby accepts the sum of $[Proposed Amount] as full and final payment for the account referenced above.

Signature: _____ Date: _____

Printed Name/Title: _____