[Date]

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

RE: POST-SETTLEMENT AUDIT AND FINAL PAYMENT RECONCILIATION

Patient Name: [Patient Name]
Date of Loss/Injury: [Date]
Account/Patient ID: [Account Number]

Dear Billing Department,

Our office has reached a settlement regarding the personal injury claim for the above-referenced patient. As we begin the process of disbursing funds held under the Letter of Protection (LOP) issued to your facility, we are conducting a final audit of the outstanding balance.

Please provide the following information within [Number] business days to ensure accurate payment:

- A final, itemized statement of all charges related to this injury.
- Verification of any payments already received from health insurance, Med-Pay, or PIP.
- Confirmation of the absolute minimum "walk-away" amount accepted to satisfy this lien in full.

Proposed Reduction Request:
Due to limited recovery funds and the necessity of satisfying multiple competing liens, we are requesting a voluntary reduction of the current balance. Our proposed settlement amount for your facility is **$[Amount]** as payment in full.

Please sign below to indicate your acceptance of this final settlement amount. Upon receipt of the signed agreement, we will issue a check and a release of lien for your records.

If we do not receive a response by [Date], we will proceed with disbursement based on the information currently available in our file.

Sincerely,

[Your Name/Firm Name]
[Phone Number]
[Email Address]

ACCEPTANCE OF FINAL SETTLEMENT

The undersigned agrees to accept $[Amount] as full and final satisfaction of all claims and liens against [Patient Name] and [Law Firm].

Signature: _____ Date: _____

Printed Name/Title: _____