[NAME OF PERSON SEEKING RELIEF]

[ADDRESS OF PERSON SEEKING RELIEF]

[PHONE NUMBER OF PERSON SEEKING RELIEF]

[eMAIL ADDRESS OF PERSON SEEKING RELIEF]

[DATE]

[NAME OF HEALTHCARE PROVIDER]

[ADDRESS OF HEALTHCARE PROVIDER]

**Re**: Account Number [ACCOUNT OR REFERENCE NUMBER FOR MEDICAL BILL]

Bill Date: [DATE OF BILL ABOVE]

To Whom It May Concern:

I write to inform you that I am unable to pay the $[BILL AMOUNT] sought in the bill above. Although I am unable to currently pay the amount owed, I am not seeking to escape my obligations for the [NAME OF PROCEDURE] I received on [DATE OF BILLED PROCEDURE]. Instead, I would like to arrive at an alternative payment plan that both of us can agree to.

Paying the amount owed is not possible given my current financial situation. My current household monthly household income is $[MONTHLY HOUSEHOLD INCOME] and my current expenses are $[MONTHLY HOUSEHOLD EXPENSES]. [EXPLANATION OF WHY THE PAYING THE MEDICAL DEBT IS NOT POSSIBLE; THIS MAY INCLUDE AN EXPLANATION OF RECENTLY CHANGED CIRCUMSTANCES, SUCH AS A LOSS OF EMPLOYMENT]

I propose the following modification: [DESCRIBE PAYMENT ALTERNATIVES, SUCH AS: TEMPORARY PAUSE IN PAYMENTS, A LARGER NUMBER OF LOWER PAYMENTS, OR LUMP SUMP SETTLEMENT]. If this is amenable, or if you would be willing to discuss other alternative terms, please contact me at your earlier convenience.

Thank you for your consideration.

Sincerely,

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(Name)