Healthcare Debt Forgiveness Inquiry

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Email Address]

[Phone Number]

[Healthcare Provider's Name]

[Provider's Address]

[City, State, ZIP Code]

Dear [Healthcare Provider's Name],

I am writing to inquire about the possibility of debt forgiveness for my outstanding medical bills. My account number is [Insert Account Number]. Due to [briefly explain your situation, e.g., financial hardship, loss of income], I am currently unable to meet my payment obligations.

I would appreciate any information regarding your debt forgiveness policies, eligibility requirements, and the application process. Please let me know if you need any documents or further information from my side.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]