

Request for Medical Debt Cancellation

Date: [Insert Date]

To: [Insert Recipient's Name]

[Insert Recipient's Title]

[Insert Hospital/Organization Name]

[Insert Address]

[Insert City, State, Zip Code]

Dear [Insert Recipient's Name],

I hope this letter finds you well. I am writing to formally request the cancellation of my outstanding medical debt with [Insert Hospital/Organization Name], account number [Insert Account Number]. Due to [briefly explain your financial hardship or situation], I am unable to make payments towards this debt.

I would greatly appreciate your consideration of my request for debt cancellation. I am hopeful that you can assist me in resolving this matter in a compassionate manner. If needed, I can provide additional documentation to support my request.

Thank you for taking the time to review my situation. I look forward to your favorable response.

Sincerely,

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]