

Medical Debt Exclusion Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Recipient Name]

[Recipient Title]

[Company/Organization Name]

[Company Address]

[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally request the exclusion of a medical debt that has been reported on my credit profile. The account in question is [Account Number], and it pertains to treatment I received on [Date of Service].

Due to [brief explanation of circumstances affecting payment, such as illness, loss of employment, etc.], I have been unable to pay this debt. I have attached documentation supporting my situation, including [list any documents, such as medical records, financial statements, etc.].

In light of these circumstances, I kindly request that you consider excluding this debt from my credit report. I believe that this action is warranted given the context surrounding my financial situation.

Thank you for your understanding and consideration. I look forward to your response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]