# Notification to Remove Medical Debt

Date: [Insert Date]

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]

[Recipient's Name]
[Recipient's Title/Department]
[Company/Organization Name]
[Company Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally dispute the medical debt associated with my account [Account Number or Reference Number], which is currently listed as [Amount Owed] due to [Brief Description of Debt]. I believe this debt is inaccurate and request its removal from my account.

Upon review of my records, I have found [Details Supporting Your Dispute, e.g., provided insurance coverage, payment evidence, or lack of service]. I kindly ask that you investigate this matter and remove the debt from my account accordingly.

Please confirm the removal of this debt in writing. I appreciate your prompt attention to this matter.

Thank you for your cooperation.

Sincerely,
[Your Name]