Request for Verification of Medical Debt

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

[Recipient's Name]

[Recipient's Company/Organization]

[Recipient's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request verification of the medical debt reporting associated with my account, as referenced in your recent correspondence dated [Insert Date]. Under the Fair Debt Collection Practices Act, I am exercising my right to request validation of this debt.

Details of the account in question are as follows:

- Account Number: [Insert Account Number]
- Date of Service: [Insert Date of Service]
- Amount: [Insert Amount]

To assist in the verification process, I request that you provide me with the following:

1. Documentation verifying the debt, including any agreements and invoices.
2. Details of the original creditor.
3. Any additional information that supports your claim of this debt.

Please send your response within 30 days of receiving this letter to the address provided above. If you fail to provide the requested verification, I respectfully request that you cease all collection activities and remove any negative reporting related to this debt from my credit report.

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

Sincerely,

[Your Name]