Medical Bill Payment Confirmation Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Billing Department Name]

[Medical Provider's Name]

[Provider's Address]

[City, State, Zip Code]

Dear [Billing Department's Contact Name],

I hope this message finds you well. I am writing to request confirmation of the payment for my medical bill associated with account number [Account Number]. The payment was made on [Payment Date] in the amount of [Amount Paid].

For my records, I would appreciate it if you could send me a confirmation of this payment at your earliest convenience.

Thank you for your assistance.

Sincerely,

[Your Name]