Medical Debt Forgiveness Appeal

Date: [Insert Date]

To: [Medical Institution/Provider's Name]

Address: [Provider's Address]

City, State, ZIP: [Provider's City, State, ZIP]

Dear [Provider's Name or Billing Department],

I am writing to formally appeal for forgiveness of my medical debt. My name is [Your Full Name], and my account number is [Account Number]. Due to [explain your circumstances briefly, e.g., financial hardship, job loss, illness], I am currently unable to pay the outstanding balance of [Amount].

I have attached relevant documentation to support my appeal, including [list any attached documents such as income statements, bills, or letters of hardship].

I kindly request that you review my situation and consider forgiving or reducing my debt. I appreciate any assistance you may provide during this challenging time.

Thank you for your attention to this matter. I hope to hear from you soon.

Sincerely,

[Your Full Name]
[Your Address]
[City, State, ZIP]
[Your Phone Number]
[Your Email Address]