Medical Debt Payment Plan Modification Request

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Creditor's Name]

[Creditor's Address]

[City, State, Zip Code]

Subject: Request for Modification of Medical Debt Payment Plan

Dear [Creditor's Name],

I am writing to formally request a modification of my current payment plan regarding my medical debt account #[Account Number]. Due to [brief explanation of circumstances such as job loss, medical expenses, or other financial hardship], I am unable to maintain my current payment arrangement.

I would like to propose a revised payment plan that would allow me to meet my obligations while also managing my financial responsibilities. Specifically, I would like to request the following terms:

- New monthly payment amount: [Proposed Amount]
- Payment frequency: [e.g., monthly, bi-weekly]
- Length of modified payment plan: [e.g., 6 months, 1 year]

I believe these changes will help me fulfill my obligation while ensuring my financial stability. I appreciate your understanding and consideration of my request.

Please feel free to contact me at [Your Phone Number] or [Your Email Address] to discuss this matter further. I look forward to your favorable response.

Thank you for your attention to this matter.

Sincerely,

[Your Name]