Date: [Insert Date]

[Your Name]

[Your Title]

[Medical Facility Name]

[Facility Address]

[City, State, Zip Code]

[Patient's Name]

[Patient's Address]

[City, State, Zip Code]

Re: Payment Plan Request

Dear [Patient's Name],

We appreciate your inquiry regarding your account balance and the request for a payment plan. We understand that managing medical expenses can be challenging, and we are here to assist you.

Your current balance is [Insert Amount]. We would like to offer you a payment plan that allows you to pay off your balance in a manageable way. The proposed plan consists of [Insert Payment Terms, e.g., monthly payments of X amount over Y months].

If you agree to this payment plan, please sign and return the enclosed agreement or contact us at [Insert Phone Number] to discuss any adjustments or concerns you may have.

Thank you for your attention to this matter. We look forward to working with you to resolve your account balance.

Sincerely,

[Your Name]

[Your Title]

[Medical Facility Name]

[Contact Information]