Debt Account Closure Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

[Medical Provider's Name]

[Medical Provider's Address]

[City, State, Zip Code]

Subject: Request for Closure of Debt Account

Dear [Medical Provider's Name],

I hope this letter finds you well. I am writing to formally request the closure of my debt account related to medical bills associated with my treatment at your facility. My account number is [Insert Account Number].

After careful review of my financial situation and payment history, I wish to confirm that all outstanding balances have been settled. I have attached copies of the payment receipts for your reference.

Please let me know if there are any further actions needed on my part to finalize the closure of my account. I would appreciate a written confirmation of the account closure at your earliest convenience.

Thank you for your attention to this matter.

Sincerely,

[Your Name]