Appeal for Reduced Medical Debt Payment Terms

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Medical Facility or Collection Agency Name]

[Address]

[City, State, ZIP Code]

Dear [Recipient's Name],

I am writing to formally request a reconsideration of my current payment terms regarding the medical debt I owe, account number [Account Number]. Due to [brief explanation of financial difficulties], I am finding it increasingly difficult to keep up with the prescribed payment plan.

Given my circumstances, I kindly ask for a review of my account and to explore the possibility of a reduced payment amount or a longer payment term. I am committed to resolving this debt in a manner that is feasible for my financial situation.

I appreciate your attention to this matter and look forward to your prompt response. Thank you for your understanding and consideration.

Sincerely,

[Your Name]