Application for Medical Debt Settlement Plan

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

[Recipient's Name]

[Medical Provider's Name]

[Provider's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a debt settlement plan for my outstanding medical bills associated with my treatment at [Facility/Provider Name]. My account number is [Account Number]. Due to [reason for financial hardship, e.g., loss of income, medical emergencies], I am unable to pay the total amount owed of [total amount].

In light of my current financial situation, I would like to propose a settlement plan that would allow me to pay the amount I owe in manageable installments. I am able to offer a monthly payment of [proposed amount] over the course of [number of months].

I appreciate your consideration of my request and I am hopeful that we can come to a mutually agreeable resolution. Please let me know if you require any additional information or documentation to support my application.

Thank you for your understanding and assistance in this matter.

Sincerely,

[Your Signature (if sending by mail)]

[Your Printed Name]