Financial Hardship Declaration for Medical Bill Reduction

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient Name]

[Medical Provider's Name]

[Provider's Address]

[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally declare my financial hardship regarding my medical bills that are currently outstanding. Due to [briefly explain your financial situation, e.g., job loss, reduced income, unexpected expenses], I am unable to afford the payments as originally agreed.

My account number is [your account number]. The total amount owed is [total amount]. I kindly request consideration for a reduction in my medical bills based on my financial circumstances. I have attached supporting documentation, including [list any documents you are including, e.g., pay stubs, bank statements, or a letter of unemployment].

I appreciate your understanding and consideration of my situation. I believe that with assistance, I can manage my debt more effectively and continue to prioritize my health. Please let me know if further information is required to process my request.

Thank you for your time and assistance.

Sincerely,

[Your Name]