Debt Validation Request Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

[Debt Collector's Name]

[Debt Collection Agency's Name]

[Agency Address]

[City, State, Zip Code]

Dear [Debt Collector's Name],

I am writing to request validation of the debt referenced in your communication dated [insert date of their letter], which claims I owe medical bills totaling [insert amount]. Under the Fair Debt Collection Practices Act, I have the right to request validation of this debt.

To assist in my evaluation, please provide the following:

- The amount of the debt,
- The name of the original creditor,
- A copy of the original invoice or statement from the medical provider,
- Proof that you are authorized to collect this debt on behalf of the creditor.

During the validation process, I request that all collection activities cease until this matter is resolved. Kindly respond within 30 days of receiving this letter.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]