Medical Debt Relief Appeal Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient's Name]

[Recipient's Title]

[Institution's Name]

[Institution's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request relief from my medical debt incurred through [Hospital/Provider Name]. Due to [explain your financial situation briefly, such as loss of income, medical emergencies, etc.], I am struggling to meet my financial obligations.

My account number is [Account Number]. The amount currently outstanding is [Amount]. I have attached supporting documents including my financial statements and any relevant information pertaining to my circumstances.

I would appreciate your consideration for either a reduction of my debt, a payment plan, or any available financial assistance programs. I am committed to resolving this issue and would be grateful for your support during this challenging time.

Thank you for taking the time to consider my request. I look forward to your prompt response.

Sincerely,

[Your Name]