[Your Name/Company Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

[Date]

[Patient Name]
[Patient Address Line 1]
[City, State, Zip Code]

Re: NOTICE OF UNPAID MEDICAL DEBT

Account Number: [Account Number]
Date of Service: [Date of Service]
Total Balance Due: $[Amount]

Dear [Patient Name],

This letter is to inform you that your account with [Medical Provider Name] is currently past due. Our records indicate that we have not yet received payment for the services provided on [Date of Service].

We understand that medical billing can be complex. If you have already sent your payment or if this balance has been paid by your insurance provider, please disregard this notice. Otherwise, please remit the full payment of $[Amount] by [Due Date].

Payment Options:

- Pay Online: [Website URL]
- Pay by Phone: [Phone Number]
- Pay by Mail: Please make checks payable to [Payee Name] and mail to the address listed above.

If you are unable to pay the full amount at this time, please contact our billing department at [Phone Number] to discuss payment plan options or financial assistance programs.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of the debt or any portion thereof, this office will assume this debt is valid.

Sincerely,

[Your Name/Signature]
[Title]
[Company Name]