[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Date]

[Debt Collector Name]
[Debt Collector Address]
[Debt Collector City, State, Zip Code]

Re: Account Number [Account Number]

To Whom It May Concern,

I am writing to formally dispute the debt associated with the account number listed above. I received your notice on [Date you received the notice] and am exercising my rights under the Fair Debt Collection Practices Act (FDCPA) to request validation of this debt.

This is a request for medical debt validation. Please provide the following information:

- The name and address of the original medical provider.
- The date(s) of service and a breakdown of the specific services provided.
- Proof that you are licensed to collect debt in my state.
- Documentation showing that your organization has the legal right to collect this specific debt.
- A copy of the original bill or statement from the medical provider.
- Verification that this debt has not already been paid by insurance or a third-party provider.

Please note that I am also requesting that you cease all collection activity, including reporting this to credit bureaus, until you have provided the requested validation. If you have already reported this to any credit reporting agencies, please mark it as "disputed."

Furthermore, please restrict all communication regarding this matter to written correspondence only. Do not contact me by telephone at my home or place of employment.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]