

**Date:** [Date]

**Patient Name:** [Patient Full Name]

**Account Number:** [Account Number]

**Procedure Type:** [Type of Medical Procedure]

**Provider Name:** [Clinic/Hospital Name]

**Provider ID:** [Tax ID/Provider Number]

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## Financing Approval Notice

Dear [Patient Name],

We are pleased to inform you that your application for medical procedure financing has been approved. This approval is designated for direct disbursement to your healthcare provider.

### Loan and Disbursement Details:

- **Approved Financing Amount:** \$[Amount]
- **Approved Provider:** [Clinic/Hospital Name]
- **Interest Rate:** [Rate]%
- **Repayment Term:** [Number] Months

### Direct Disbursement Terms:

The funds listed above will be paid directly to [Clinic/Hospital Name] upon receipt of the final invoice and confirmation that the procedure has been completed. These funds are restricted for the specific medical services outlined in your application and cannot be issued directly to the patient.

### Next Steps:

1. Present this letter to the billing department at [Clinic/Hospital Name].
2. Sign the attached Loan Agreement and Disclosure Statement.
3. The provider must submit a Payment Request Form to our office following the procedure.

If you have any questions regarding your account or the disbursement process, please contact our funding department at [Phone Number] or [Email Address].

Sincerely,

[Name of Officer]

[Title]

[Financing Company Name]