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

[Date]

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

Re: Account Number [Insert Account Number]

Dear [Name of Debt Collector],

I am writing this letter in response to your notice dated [Date of notice you received] regarding a medical debt you claim I owe to [Original Medical Provider].

Pursuant to my rights under the Fair Debt Collection Practices Act (FDCPA), I am formally requesting that you provide validation of this debt. Please provide the following information:

- Proof that you are authorized to collect this debt.
- A complete breakdown of the amount claimed, including the date of service and the specific medical services provided.
- A copy of the original agreement or contract signed by me.
- Documentation showing the last payment made on this account, if any.
- Your collection agency license number for this state.

Please note that this is not a refusal to pay, but a request for verification. Furthermore, please ensure that your response complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. Do not share my private medical information with any third-party credit reporting agencies while this debt is in dispute.

If you fail to provide the requested validation within 30 days, I expect you to cease all collection activities and remove any derogatory information related to this account from my credit reports.

Sincerely,

[Your Signature]

[Your Printed Name]