

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

[Date]

[Name of Medical Provider or Billing Department]  
[Attention: Billing Department]  
[Address]  
[City, State, Zip Code]

**RE: Account Number: [Your Account Number]**  
**Patient Name: [Patient Name]**  
**Total Balance Due: \$[Total Amount]**

To Whom It May Concern,

I am writing regarding the outstanding balance on the account mentioned above. I would like to resolve this debt; however, due to my current financial situation, I am unable to pay the full balance in a single payment.

I would like to propose a formal payment plan to settle this account. I am offering to pay **[\$Monthly Amount]** per month, starting on **[Start Date]**, and continuing on the **[Day of the Month]** of each month until the balance is paid in full.

By accepting this payment plan, I request that you:

- Stop all further collection actions against me.
- Ensure that this account is not referred to a third-party collection agency.
- Refrain from reporting negative information regarding this specific debt to credit bureaus as long as payments are made as agreed.

Please send me a written confirmation if this proposal is acceptable to you. Once I receive your written agreement, I will send my first payment immediately.

Thank you for your time and for working with me to resolve this matter.

Sincerely,

[Your Signature]

[Your Printed Name]