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

[Date]

[Name of Debt Collection Agency]
[Address of Debt Collection Agency]
[City, State, Zip Code]

RE: Account Number: [Account Number]
Original Creditor: [Name of Hospital or Medical Provider]
Reference Number: [Reference Number]

Dear [Name of Debt Collector or Compliance Department],

I am writing to formally dispute the balance currently listed for the above-referenced medical account. While I acknowledge receiving basic information regarding this debt, the current amount you are seeking to collect does not align with my records or the insurance explanations of benefits (EOB) I have received.

Please provide a partial validation and an updated balance statement that includes the following details:

- An itemized statement of all medical services rendered, including dates of service.
- A breakdown of the original charges versus payments made by my insurance provider.
- Evidence of any adjustments, write-offs, or "contractual obligations" applied to the bill.
- A list of all payments credited to this account from any source since the date of service.
- Verification that this debt does not violate the "No Surprises Act" or state-specific medical billing laws.

I am requesting that you investigate these discrepancies and update your records to reflect the accurate balance. Until this investigation is complete and the correct balance is verified, I request that you cease reporting any inaccurate information to the credit reporting agencies.

Please provide the requested documentation and an updated account summary within 30 days of receiving this letter.

Sincerely,

[Your Signature]

[Your Printed Name]