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

Date: [Current Date]

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

RE: Notice of Disputed Debt and Request for Account Closure and Deletion

Account Number: [Your Account Number]
Original Creditor: [Healthcare Provider Name]

To Whom It May Concern,

I am writing to formally dispute the above-referenced medical debt. This letter serves as notice that I do not owe the amount claimed, and I am requesting the immediate closure of this account and the deletion of any associated information from your records and credit reporting agencies.

I am disputing this debt based on the following reason(s):
[Insert reason, e.g., Debt was paid in full, Insurance has processed payment, Incorrect billing amount, or Debt is past the statute of limitations].

Under the Fair Debt Collection Practices Act (FDCPA) and the Fair Credit Reporting Act (FCRA), I am exercising my right to dispute this information. If you have reported this debt to any credit reporting agency (Equifax, Experian, or TransUnion), I demand that you notify them immediately that this account is disputed and request its permanent removal from my credit file.

Please provide written confirmation within thirty (30) days that this account has been closed, the balance has been set to zero, and that all requests for deletion from credit bureaus have been submitted.

Furthermore, please cease all further collection efforts and communication regarding this matter, except for the required confirmation of account closure.

Sincerely,

[Your Signature]

[Your Printed Name]