[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: Notice of Disputed Medical Debt and Request for Deletion

Account Number: [Your Account Number as it appears on credit report]

To Whom It May Concern,

I am writing to formally dispute the validity of the above-referenced medical debt currently being reported on my credit file. I do not recognize this debt and do not believe it belongs to me.

Under the Fair Credit Reporting Act (FCRA) and the Fair Debt Collection Practices Act (FDCPA), I am requesting that you provide full and complete documentation to verify the accuracy of this claim. To date, I have not received sufficient documentation proving that I owe this debt, the exact amount owed, or that your agency has the legal authority to collect it.

Please provide the following items:

- A detailed breakdown of all charges and payments associated with this account.
- A copy of the original signed contract or agreement to pay for services.
- Proof of your legal authorization to collect this debt in my state.
- Verification that the reporting of this debt complies with the No Surprises Act and HIPAA privacy regulations regarding the disclosure of medical information.

If you cannot provide original, itemized documentation verifying this debt within 30 days of receiving this notice, you are required by law to cease collection activities and remove all information regarding this account from my credit reports with Equifax, Experian, and TransUnion immediately.

I will be monitoring my credit reports to ensure this inaccurate information is deleted. Failure to provide verification or remove this listing will result in a formal complaint to the Consumer Financial Protection Bureau (CFPB) and my State Attorney General.

Sincerely,

[Your Signature]

[Your Printed Name]