

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

[Date]

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

**RE: Notice of Disputed Debt and Request for Validation**

Account Number: [Account Number]  
Creditor Name: [Original Health Care Provider Name]

To Whom It May Concern,

I am writing to formally dispute the debt mentioned above. I received your notice on [Date of Letter Received] and am exercising my rights under the Fair Debt Collection Practices Act (FDCPA) and the Fair Credit Reporting Act (FCRA) to request validation of this debt.

I dispute the validity of this debt in its entirety. Please provide the following information to verify this claim:

- The name and address of the original medical provider.
- A detailed breakdown of all charges, including dates of service and CPT codes.
- Proof that your company is licensed to collect debt in my state.
- A copy of the original agreement or contract signed by me, agreeing to pay the amount claimed.
- Proof that the statute of limitations for collecting this debt has not expired.
- A statement regarding whether this debt has been submitted to my insurance provider and the result of that claim.

Under the FDCPA, once a debt is disputed, you must cease all collection efforts until you provide the requested validation. Furthermore, if you have reported this debt to any credit reporting agencies, you are required by law to mark the account as "disputed."

Please note that this is not a refusal to pay, but a request for verification of the debt's accuracy and your legal right to collect it. I look forward to receiving the requested documentation within 30 days.

Sincerely,

[Your Signature]

[Your Printed Name]