

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

[Date]

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

**RE: Notice of Disputed Debt and Acknowledgment of Prior Payment**

Account Number: [Your Account Number]  
Original Creditor: [Name of Hospital or Medical Provider]  
Amount Disputed: [Dollar Amount]

To Whom It May Concern,

I am writing to formally dispute the validity of the above-referenced medical debt. This letter serves as notice that this debt has already been satisfied through prior payment.

I have attached documentation as proof of payment, which includes:

- [Type of proof, e.g., Cancelled check, Credit card statement, or Receipt]
- [Date of payment]
- [Transaction reference number, if applicable]

Under the Fair Debt Collection Practices Act (FDCPA) and the Fair Credit Reporting Act (FCRA), I request that you:

1. Immediately cease all collection efforts regarding this specific balance.
2. Review your records to acknowledge the prior payment.
3. Provide written confirmation that this debt is considered paid in full and that the account balance is zero.
4. Ensure that this disputed debt is not reported to any credit bureaus, or if it has been reported, that the entry is removed or corrected immediately.

Please provide your response to this dispute within 30 days of receipt of this letter. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List attached documents]