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

[Date]

[Billing Department Name]
[Medical Facility/Provider Name]
[Address]
[City, State, Zip Code]

RE: Notice of Payment in Full and Account Resolution

Account Number: [Your Account Number]
Invoice/Bill Number: [Invoice Number]
Date of Service: [Date of Treatment]

To Whom It May Concern,

This letter is to formally confirm that the above-referenced medical account has been paid in full. A payment in the amount of $[Amount Paid] was made on [Date of Payment] via [Payment Method: Credit Card, Check #, etc.].

I request that you update your records immediately to show a zero ($0.00) balance for this account. Additionally, please provide a formal "Paid in Full" letter or a final statement reflecting the closed status of this account for my personal records.

If this account was previously reported to any credit reporting agencies or third-party collection agencies, I request that you notify them immediately that the debt has been satisfied in full and instruct them to update my credit profile accordingly.

Please confirm receipt of this letter and the resolution of this account within [Number, e.g., 15] business days.

Sincerely,

[Your Signature]

[Your Printed Name]