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

[Date]

[Debt Collector/Hospital Name]
[Department, if known]
[Address]
[City, State, Zip Code]

Re: Account Number: [Account Number]
Reference Number: [Reference Number]
Patient Name: [Name on the medical bill]

Dear [Contact Person or Collections Department],

I am writing to formally dispute the debt associated with the account listed above. I have recently discovered that I am a victim of identity theft, and this medical debt was incurred fraudulently using my personal information without my consent or knowledge.

I am requesting that you immediately cease all collection activity regarding this account, close the file in my name, and provide written verification that the account has been closed and the balance cleared.

In support of this claim, I have enclosed the following documents:

- A copy of my Identity Theft Report (e.g., FTC Identity Theft Affidavit or Police Report).
- A copy of my government-issued identification.
- [Optional: Any other supporting documentation, such as proof of residence elsewhere during the date of service].

Furthermore, if this account has been reported to any credit reporting agencies (Equifax, Experian, or TransUnion), I request that you notify them within 30 days that this account was the result of identity theft and should be deleted from my credit file entirely.

Please provide written confirmation within 30 days that this matter has been resolved and that I am no longer held responsible for this debt.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List the documents you are including]