

Medical Debt Validation Letter

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Your Contact Information]

[Date]

To:

[Medical Collection Agency]

[Agency Address]

[City, State, ZIP Code]

Subject: **Debt Validation Request for Medical Bill – Account #[Your Account Number]**

Dear [Debt Collector's Name],

I recently received a notice regarding an outstanding medical bill. Under the **Fair Debt Collection Practices Act (FDCPA)**, I request that you verify the validity of this debt.

Please provide:

- **A copy of the original medical bill from the provider**
- **Proof of insurance claim rejection, if applicable**
- **An itemized list of services and associated costs**
- **Evidence your agency is authorized to collect this debt**

If you cannot provide **legal validation**, please **remove this debt from my record immediately**. Any reporting to credit bureaus without verification is unlawful.

Please respond within **30 days** of receiving this letter.

Sincerely,
[Your Name]