Medical Bill Payment Waiver Template

Patient Information

Patient Name:

Patient Address:

Account Number:

Date of Service:

Medical Provider Information

Provider Name/Facility:

Contact Number:

Waiver Request Details

Amount Owed:

Reason for Payment Waiver Request:

I, the above-named patient, respectfully request a waiver of the medical bill indicated. I certify that the information provided is true and accurate to the best of my knowledge. I understand this request is subject to the provider's review and approval.

Patient Signature

Date