

# INVOICE

**Re: {Insert Contact Name}**

**C/O {Insert Law Firm}**

**Invoice #:{Insert Case #}**

**Invoice Date: 3/5/2025 Date of Loss: {Insert Date of Loss}**

Surgical Capital Solutions, Inc, hereby places you on notice that it has assumed the balance/Letter of Protection rights for your client, **{Insert Contact Name}**for the provider(s) listed below.

Please make sure that our balance is resolved with us and not with the provider since they transferred legal rights upon the sale of this bill, they are not entitled to negotiate nor receive payment on this matter.

**{Insert Medical Facility} {Insert DOS (Date of Service)} – {Insert Through Date} {Insert Billing Amount}**

We are more than willing to work with your office and will request your proper attention to this matter. Please confirm receipt of this notice.

# Please Make Checks Payable To: Surgical Capital Solutions, Inc.

**2963 Gulf to Bay Blvd. Suite 120 Clearwater, FL 33759**

Questions regarding this statement? Call **(888) 753-5631** Fax: (813) 437-1411