

# SETTLEMENT REDUCTION REQUEST

**Healthcare Provider Information:**

Provider Name: City General Hospital  
Address: 123 Medical Center Dr, Anytown, ST 12345  
Phone: (555) 123-4567

**Patient Information:**

Patient Name: John Doe  
Date of Birth: 01/15/1980  
Address: 456 Patient Ave, Anytown, ST 12345

**Service Information:**

Service Date: 03/15/2024  
Description: Emergency Room Visit - Chest Pain

**Financial Summary:**

Original Billed Amount: \$2500.00  
Amount Paid: \$500.00  
Current Balance Due: \$2000.00

**Settlement Offer:**

Proposed Settlement Amount: \$800.00  
Settlement Terms: Full and final settlement of all claims. Payment due within 30 days.

**Contact Information:**

Settlement Department  
Phone: (555) 987-6543  
Email: settlements@settlementcalc.com

This settlement offer is valid for 30 days from the date of this letter.  
Please contact us to discuss this settlement proposal.

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