Letter Seeking to Negotiate a Reasonable Payment Plan

For use after July 22, 2025, when the Reasonable Payment Plan requirement of the Louisa Carman Medical Debt Relief Act goes into effect. Fill in the information indicated in the brackets and then delete the brackets. The letter also contains instructions on how to complete the letter that are in all capital letters and inside brackets and those instructions and brackets should also be deleted before you send the letter.

This letter should be sent to the health provider/debt collector by the patient, either insured or uninsured, or the person such as a parent responsible for paying the medical debt.

Purpose: To start to negotiate a Reasonable Payment Plan if you believe the debt is valid. If you do not believe the debt is valid, use the Letter Denying or Disputing the Debt. Please note that if the provider offers you a Payment Plan and you do not believe you owe the money, you can still enter the settlement agreement and assert your defense that the bill is invalid in the event you do not pay that amount and you are sued.

Note: The Payment Plan requirement extends to both insured and uninsured patients. **If you are insured**, the amount of the bill will depend on whether you have met your deductible, and whether your health plan requires you to pay a percentage of the charge your insurer has negotiated for the services you received. If you are uninsured, there is no prior negotiated rate and you will almost certainly be charged a higher amount than someone who is insured. Therefore, in this letter, you want to first try to lower the amount of the bill (typically, to the Medicare rate for the service received) and then undertake the calculations set forth in the letter.

(DATE)

(PROVIDER OR DEBT COLLECTOR NAME

ADDRESS)

Re: Invoice No. _____

Bill Amount $_____

Services Rendered on_____(Date(s)_____

Dear (Name of Doctor/Hospital/Practice/Debt Collector or Collection Agent):

I am writing regarding the medical bill identified above in the amount of $ _____. (IF YOU ARE INSURED, CHOOSE THE NEXT PARAGRAPH AND IF YOU ARE NOT INSURED, CHOOSE THE SECOND PARAGRAPH. DELETE THE PARAGRAPH YOU DO NOT CHOOSE AND ALSO THESE INSTRUCTIONS.)

I acknowledge that the bill is accurate and that I owe (Name of Physician, Hospital or Provider Group) this amount for services I received on (Date(s)). However, pursuant to the Louisa Carman Medical Debt Relief Act, N.J.S.A. 56:11-28 et seq., you are required to offer me a Reasonable Payment Plan before you can start medical debt collection efforts.

(OR)

I acknowledge that the bill is for services that I received from (Name of Physician, Hospital or Provider Group) on (Date(s)). However, I believe that as an uninsured patient, I have been charged an unreasonable amount. Instead, my research indicates that the Medicare rate(s) for the services I received is/are $ _____. Accordingly, I am offering to pay that amount to settle your claim against me. Furthermore, pursuant to the Louisa Carman Medical Debt Relief Act, N.J.S.A. 56:11-28 et seq., you are required to offer me a Reasonable Payment Plan before you can start medical debt collection efforts.

(CONTINUE THE LETTER IN BOTH SITUATIONS AS FOLLOWS:)

I understand that these Payment Plans can last from six months to five years, possibly even longer, based on how much I owe and my ability to pay. The amount of the monthly payments cannot be greater than 3% of my individual monthly income, and the annual interest rate cannot exceed 3%.

Based on these parameters set forth in the law, I am proposing to pay you $ _____ per month for (X) number of months. This offer is based on the fact that my monthly income is $_____. I will supply proof of my income on the condition that you agree to keep the information confidential and not share it with any third-party or use it for any purpose other than calculating a Reasonable Payment Plan.

Please let me know if this proposal is acceptable to you. If it is, please send me a signed, written agreement that reflects the terms I have outlined above.

If you desire to discuss this matter with me further, I can be reached at (Phone Number) and/or (Email).

Thank you for your consideration and quick attention to this matter.

Sincerely,

(Name of Patient
Address of Patient
Phone Number
Email Address)

NOTICE: This is a public document, which means the document as submitted will be available to the public upon request. Therefore, do not enter personal identifiers on it, such as Social Security number, insurance policy number, active financial account number, active credit card number or military status.

Filing Information Pro Se Litigant

Name _____

Address _____

_____

Email Address _____

Telephone Number _____ext._____

_____ X		
	:	
Name _____	:	Superior Court of New Jersey
	:	Law Division, Special Civil Part
Plaintiff,	:	_____ County
	:	
	:	Docket Number: DC- _____
vs.	:	**Civil Action**
Name _____	:	
	:	**ANSWER**
Defendant,	:	
_____X		

Defendant, __(Name)_____, denies owing the debt of $_____ to the Plaintiff.

REPLY

AFFIRMATIVE DEFENSES

(CHECK THE APPROPRIATE STATEMENT(S) BELOW. WHICH SET FORTH WHY YOU CLAIM YOU DO NOT OWE MONEY TO THE PLAINTIFF OR OWE LESS THAN THE PLAINTIFF IS CLAIMING, AND DELETE THOSE DEFENSES THAT ARE NOT APPLICABLE. DELETE THESE INSTRUCTIONS BEFORE FILING THE ANSWER.)

☐ The bill has been paid. (State facts supporting this assertion below)

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☐ The dollar amount claimed by the plaintiff(s) is incorrect. (State facts supporting this assertion below)

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☐ The debt sued on has been reported to a credit reporting agency in violation of NJ law and is thus, automatically void. (State facts supporting this assertion below)

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☐ I was not offered a Reasonable Payment Plan for the debt or I was offered a plan but it was not reasonable, in violation of NJ law. (State facts supporting this assertion below)

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☐ I am on Medicaid or NJ Family Care and I was improperly billed for medically necessary services. (State facts supporting this assertion below)

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☐ The debt sued on was incurred for health care provided at a hospital and I was never given the opportunity to apply for Charity Care or I was found eligible for Charity Care but was improperly charged for services that should have been fully covered or I was charged above the amount allowed by law for someone with my income. (State facts supporting this assertion below)

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☐ The debt sued on was incurred for health care provided at a hospital and I was found eligible for Charity Care but one or more of the physicians or other health care providers who provided care at the hospital failed to bill me accordingly, in violation of the law. (State facts supporting this assertion below)

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☐ The plaintiff is not a health care provider and provided no health care services to me and cannot prove that they are entitled to collect any amount owed for the medical services giving rise to the debt that is the subject of this lawsuit. (State facts supporting this assertion below)

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☐ I reached an agreement with the plaintiff or with the health care provider who provided the health care services to pay a different amount to satisfy the debt that is the subject of this lawsuit and I have satisfied the terms of that agreement and thus no longer owe the debt or owe only a lesser amount that I will satisfy in accordance with the agreement I made with the plaintiff or health care provider. (State facts supporting this assertion below)

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☐ The claim or the amount of the claim is unfair. (State facts supporting this assertion below)

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☐ The medical equipment or services were not provided. (State facts supporting this assertion below)

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☐ The medical equipment received was defective. (State facts supporting this assertion below)

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☐ I/We did not request or agree to the medical equipment or services. (State facts supporting this assertion below)

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☐ I am a victim of identity theft or mistaken identity. (State facts supporting this assertion below)

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☐ The time (six years) has passed for plaintiff to sue on this debt. (State facts supporting this assertion below)

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☐ This debt has been discharged in bankruptcy. (State facts supporting this assertion below)

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☐ A lawsuit was previously filed and the claim has been resolved. (State facts supporting this assertion below)

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☐ Defendant is in the military on active duty. (State facts supporting this assertion below)

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☐ Plaintiff did not file this lawsuit in the proper place. (State facts supporting this assertion below)

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☐ Other – Set forth any other reasons why you believe money is not owed to the Plaintiff(s). (You may attach more sheets if you need to and attach any documents that may prove your assertions to any of the defenses set forth above)

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☐ Trial by jury is requested and an extra $100 cash, check or money order is submitted.

☐ Trial by jury is requested and I have submitted an application for a waiver of the $100.00 fee.

The Judiciary will provide reasonable accommodations to enable individuals with disabilities to access and participate in court events. Please contact the local ADA coordinator to request an accommodation. Contact information is available at njcourts.gov.

The New Jersey Judiciary provides court-interpreting services. If you need an interpreter, notify the court as soon as possible. Contact information is available at njcourts.gov.

Certification

I certify, to the best of my knowledge: (Must check one)

☐ that the above matter is not the subject of any other court action or arbitration proceeding now pending or contemplated, or

☐ that the following actions or arbitration proceedings are pending or contemplated

_____

AND (Must check one)

☐ that no other parties should be joined in this action; or

☐ that the following persons or entities should be joined in this action

_____

I certify that confidential personal identifiers have been redacted from documents now submitted to the court and will be redacted from all documents submitted in the future in accordance with Rule 1:38-7(b).

I further certify that this answer was served by me upon all existing parties.

_____ s/_____
Dated Defendant's Signature

_____
Defendant's Name - Typed or Printed

☐ **Demand for Production of Documents Pursuant to R. 4:18-2.** By checking this box, demand is made for production of all documents or papers referred to in the pleading for which this answer is provided, within 5 days of this demand.

Instructions for Completing Special Civil Answer in Medical Debt Case

A. The defendant is you, the person who is being sued, and the plaintiff is the person who is suing you.

B. At the top left of the form under the section labeled Pro Se Litigant, enter your name, address, daytime phone number and email address. If you are not an attorney, leave the NJ Attorney ID field blank.

C. In the section for plaintiff's information, enter the plaintiff's name, address and daytime phone number. Make sure to check the box if the plaintiff's address and/or phone number have changed since the initial filing.

D. In the section for defendant's information, enter the name(s), current address(es) and daytime phone number(s) of the defendant(s) listed on the complaint.

E. On the right side of the form, enter the County and Docket No. assigned to the case by the court. (You can get this information from the Complaint filed against you.)

F. In the section below where Defendant denies owing the debt to the Plaintiff, check the appropriate statement(s) which set forth why you claim you do not owe the money to the plaintiff (select ALL that apply); or choose the box marked "Other" and explain your position.

G. Indicate if you want a trial by jury. If so, select the appropriate statement – trial by jury requested and you are paying the extra fee or trial by jury requested and you have submitted an application for a Fee Waiver. Enclose either a $130 check or money order ($100 for jury and $30 for the Answer filing fee) made payable to the Treasurer, State of New Jersey, or your completed application for a fee waiver.

H. In the Certification area, check the applicable box in each section, advising the court of any other pending actions involving the same parties. Provide information about those other claims or lawsuits (if any) and advise the court if any other parties should be joined to this lawsuit.

I. **IMPORTANT:** Carefully review the Certifications made and double check that you have complied with the Certifications before moving to the next step. This means that you must make sure that you do not need to bring anyone else into the case or that you advise the Court if another party should be brought into the case. A frequent example is when a hospital sues a patient for payment of a bill, but the patient believes that the insurance company should pay the bill instead. The insurance company needs to be brought into the case. If you are in a situation similar to this example, DO NOT use this Answer Form. Instead use packet 11968 on the court website - How to Answer a Complaint in the Special Civil Part with a Counterclaim, Cross-claim and/or Third-Party Complaint.

J. If the Answer or any of the copies of papers that you attach to the Answer contain a Social Security number, insurance policy number, active financial account number, active credit card number or information as to an individual's military status you must redact (black out) this information so that it cannot be seen, unless any such personal identifier is required to

be included by statute, rule, administrative directive or court order. If an active financial account is the subject of your case and cannot otherwise be identified, you may use the last four digits of the account to identify it. Once you have confirmed that none of these personal identifiers are on the papers that you are filing, you must sign and date the Certification that indicates "I certify that personal identifiers have been redacted from documents now submitted to the court and will be redacted from all documents submitted in the future in accordance with Rule 1:38-7(b)."

NOTE: Do Not redact (black out) this information in the original papers that you are keeping since you may have to show them to the court at some point.

K. On the line above Dated, clearly print or type the date on which you sign this form, sign your name on the line above Defendant's Signature and clearly print or type your name on the line below your signature.

L. If you would like a copy of the documents or papers referred to in the Complaint, check The Demand for Production of Documents box located at the bottom of the form. Review all steps for completion before mailing your form. We recommend that you check the box.