Debt Collection Agency

Toll Free: 800-280-9770 Fax: 800-280-7590

COLLECTION PLACEMENT FORM

CLIENT NAME: _____

FEE STRUCTURE: / / _____

HAS THIS ACCOUNT BEEN PLACED WITH ANOTHER AGENCY? ___YES ___NO

Patient/Customer Name:			Responsible Party/ Guarantor		
Patient Address:			Address:		
City:		State:	City:	State:	
Zip Code:		DOB:	Zip Code:	DOB:	
Social Security#:			Social Security#:		
Home Phone:			Home Phone:		
Work Phone:			Work Phone:		
Alt Phone:			Alt Phone:		

Date of Service/ Invoice Date:	Total Charge:	Paid:	Adj:	Balance:
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
Total:	$_____	$____	$___	$_____

		Billed?
Primary Insurance Carrier:	_____	Y___ N___
Secondary Insurance Carrier:	_____	Y___ N___
Insurance Denial reason:	_____	
Comments:	_____	
	_____	