Thank you for choosing Creditors Collection Service to service your collection needs. Below you will find information we would ideally like to receive when you ***MANUALLY*** place your account(s) for collection. The more *current* information you provide us, the more effective we will be in our attempts for recovery. This information may be either faxed to *(866) 512-4037* or mailed to our office at PO Box 21504, Roanoke, VA 24018. To save you time, if this information is available from your computer with a print screen (admissions form/original contract) with current demographic information, you may simply copy that, include the current balance due and the date of last service and send to us rather than completing this form. In the future you would like to send your accounts *electronically* using our encrypted website and Excel, our IT department at (540) 772-6600 ext 8016 will be happy to provide assistance:

1-Client (Creditor) Name _____

2- Client (Creditor) Number (assigned by CCS) _____

3- Consumer (Debtor) Account Number (assigned by you) _____

4-* Current Balance (Amount placed for collection) _____

5-*Date of Last Charge _____

6- Responsible Name / relationship to patient _____

7- Responsible Physical Address & Mailing Address _____

8-*Responsible Social Security Number & Date of Birth _____

9- Responsible Home Phone _____

10- Responsible Cell Phone _____

11-Responsible Employer, Employer Address & Work Phone _____

Required for Credit Bureau Reporting

12-Spouse Full Name _____

13-Spouse Social Security Number & Date of Birth _____

14-Spouse Home Phone _____

15-Spouse Cell Phone _____

16-Spouse Employer, Employer Address & Work Phone _____

Additional Info needed from Medical Clients

(if different from Responsible)

17-Patient Full Name _____

18-Patient Address _____

19-Patient Social Security Number & Date of Birth _____

20-Patient Home Phone _____

21- Patient Cell Phone _____

22-Emergency Contact Name and Phone _____

23-Patient Employer, Employer Address & Work Phone _____

24-Type/Description of Service _____

25-Physician/Referring Physician _____

26-Primary Insurance Name/Address/Phone _____

27-Primary Insurance Holder/relation to patient _____

28-Primary Insurance ID/policy number _____

29-Primary Group Number _____

Submitted by: _____ Date: _____