



CLAIM PLACEMENT FORM

CLIENT INFORMATION			
* Name:		Check if Yes	
* Client Number:		<input type="checkbox"/> Pre-Collection Apply?	
* Address:		<input type="checkbox"/> Would you like to have us call and discuss your collection problems?	
* City:		<input type="checkbox"/> Has mail been returned by the post office?	
* State:		<input type="checkbox"/> Is the account disputed?	
* Zip Code:			
* Phone Number:			
* Authorized By:			
Title:			
* E-mail			
DEBTOR'S INFORMATION			
* Account Number:		Employer:	
* Debtor's Name:		Phone:	
Debtor's SSN:		Work Phone:	
Debtor's Spouse:		Date of Last Payment:	
Spouse SSN		Spouse Phone:	
* Address:		* Date of Last Charge:	
* City		* Amount:	
* State		* Costs:	
* Zip Code		* Total:	
Message:			

*** INDICATES REQUIRED FIELD**

SAVE

EMAIL

Note: the above buttons only work if you have downloaded this file and opened in Adobe Reader. If you are viewing this in a web browser please save it using the buttons to the bottom right.