CCS Financial Systems

Medical/Dental/Retail Delinquent Account Placement Form

"Your Accounts Receivable Management Company"

MAIL OR FAX TO: **CCS Financial Systems, Inc.**
P.O. Box 60550
Harrisburg, PA 17106

Phone 717-652-8020 / 800-520-8827
Fax 717-652-8845 / 800-520-5073

Date: _____

PLEASE ACCEPT THE FOLLOWING DELINQUENT ACCOUNTS FOR COLLECTION:

Debtor's Name _____

Address _____

City _____ State _____ Zip _____

Social Security No. _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Employer _____ Phone _____

Spouse _____ Spouse Cell Phone _____

Spouse's Employer _____ Phone _____

Ins Billed Yes ____ No ____ Mail Returned Yes ____ No ____

Patient Information _____

Additional Information _____

Account Detail

Account No. _____

Date of Service _____

Date of Last Payment _____

Amount Owed _____

Collection Costs _____
(If Applicable)

Total to Collect _____

Debtor's Name _____

Address _____

City _____ State _____ Zip _____

Social Security No. _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Employer _____ Phone _____

Spouse _____ Spouse Cell Phone _____

Spouse's Employer _____ Phone _____

Ins Billed Yes ____ No ____ Mail Returned Yes ____ No ____

Patient Information _____

Additional Information _____

Account Detail

Account No. _____

Date of Service _____

Date of Last Payment _____

Amount Owed _____

Collection Costs _____
(If Applicable)

Total to Collect _____

IMPORTANT: PLEASE COMPLETE SECTION BELOW:

NAME OF FINANCIAL INSTITUTION _____ ADDRESS _____

PLACEMENT AUTHORIZED BY _____ TITLE _____ TEL NO. _____ PREFERRED CONTACT TIME _____