

# Group Name

Practice Address

Billing Address:

## Facsimile Transmittal

ATTN: Peggy

Fax #:

Pages (including cover): \_\_\_\_\_ Date: \_\_\_\_\_

From:

### CLIENT REQUEST FOR CLOSE & RETURNS

Account #	Patient Name / Responsible Name	Date of Service	Amount

Office:  
Tax ID #

♦ Fax  
♦ NPI