

ENROLLMENT FORM



CLIENT INFORMATION

Sales Representative: _____ Service Representative: _____
Contact Name: _____ Company Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ E-mail: _____

I.S. INFORMATION

Software Vendor: _____ Version Number: _____
In-House Tech Contact: _____ Phone: _____ - _____ - _____ E-mail: _____
Preferred Data Transmission Method: FTP Modem VPN Other _____
E-mail File Receipt Confirmation to: _____ E-mail: _____

SERVICE INFORMATION

Service Requested: Statements Letters HCFA UB92 Other _____
Billing Cycle Daily* Weekly Monthly Other _____
**Monthly volumes must exceed 10,000 per month to qualify for daily processing*
Estimated Monthly Volume: _____ Multiple Pages: Yes No
Credit Cards Accepted: Visa Mastercard Discover American Express Other _____
Postal Endorsements: Address Service Requested Return Service Requested Forwarding Service Requested

ADDITIONAL INFORMATION

Additional Service Requests: Fast Forward Special Inserts Online Bill Payment and Presentation

IMPORTANT: Medical Electronic Billing must receive a postage deposit prior to processing any live files. No statements will be processed or mailed without receipt of postage deposit. See Postage Credit Form, opposite page. Please Initial: _____

Agreed Upon Sales Price: 1st Page _____ 2nd Page _____ Inserts _____ Fast Forward _____

Signature: _____ Date: _____ Title: _____

Please send completed form to:

By Fax: 239.482.8764
By Mail: 2129 Andrea Lane
Fort Myers, FL 33912-1903

FOR INTERNAL USE ONLY

Account Number: _____
User Name: _____
Password: _____