MEDICAL RECOVERY SERVICES

Taking your business from red to black

To: Healthcare Provider
From: Medical Recovery Services
Date: May 22, 2019

Guarantor:
Account #:

Dear Healthcare provider,

I hereby authorize Medical Recovery Services to receive, inspect, or copy any billing records, medical records, opinions, other documents, and or information regarding the stated account/accounts that are in question in the amount of $_____

_____ _____

Signature Date

Please return signed form to PO Box 51178 Idaho Falls, ID 83405 or fax to (208) 359-1491

This is an attempt to collect a debt.
Any information obtained will be used for that purpose.