ACS - MIHL **Request for Medical/Dental/Podiatry/Optometry/Chiropractic Service Cancellation**

PART I – TO BE COMPLETED BY THE BORROWER (COMPLETE IN INK)

Name	Social Security #	ACS Account # (if available)
Street Address	City	State
Zip	Date of Birth	Email Address
Home Phone #	Cell Phone #	Work Phone #

MEDICAL/DENTAL/PODIATRY/OPTOMETRY/ CHIROPRACTIC SERVICE CANCELLATION

BEGINNING (mm/dd/yyyy)	ENDING (mm/dd/yyyy)

Altered dates will not be accepted

THIS IS TO CERTIFY THAT I **WAS** EMPLOYED AS A **FULL-TIME** LICENSED MEDICAL PHYSICIAN/GENERAL DENTIST/PODIATRIST/OPTOMETRIST/CHIROPRACTOR FOR THE ABOVE DATES AT:

Clinic Name		Clinic Street Address
City, State, Zip	County	Telephone #

THIS FORM IS INVALID WITHOUT BORROWER'S SIGNATURE, SOCIAL SECURITY NUMBER, BEGINNING AND ENDING DATES, AND PART II CERTIFICATION.

I HEREBY CLAIM THAT THE ABOVE INFORMATION IS TRUE.

MD's Only: Circle practice type

Family Medicine Internal Medicine OB/GYN Pediatric

X

Borrower's Signature Date

PART II – TO BE COMPLETED BY HUMAN RESOURCE DEPARTMENT

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X ______________________________ ______________

Signature of Authorizing Official Date

Printed Name, Title, and Address of Official Telephone #		Official Stamp or Seal If no stamp or seal is available, please provide letterhead certification.
Dates Employed **Full-time** (mm/dd/yyyy)	From:	To:
Dates Employed **Part-time** (mm/dd/yyyy)	From:	To:

RETURN FORM TO:
ACS, INC. – ATTN: LINDA
900 Commerce Drive, Ste. 320
Oak Brook, IL 60523
800.432.2372 ext 2788 FAX 630.203.2796

PART III FOR OFFICE USE
PROCESSED BY: ______________ DATE: ____________
(06-07)