



YOUR COMPLETE AUTOMOTIVE CARE CENTER

Family Owned and Operated Since 1956

ATTN CLAIM REP: _____

FAX NUMBER: _____

DATE: _____

FROM: _____
PHONE: _____
FAX: _____

DIRECTION TO PAY

I authorize the insurance company to send payments for repairs directly to Auto Service and Tire, Inc.

I also understand this DTP is required so that my vehicle may be released upon completion of repairs.

Customer Name

Date

CLAIM INFORMATION:

INSURANCE CO: _____

INSURED: _____

CLAIM NUMBER: _____

DATE OF LOSS _____

PLEASE MAKE ALL PAYMENTS TO

Auto Service and Tire, Inc.
1590 Blue Hill Avenue
Mattapan, MA 02126
Mass RS# 568 Exp. Date 5/31/2012
Tax ID# 042585667
Hazardous Waste# MAD060087525
Mass Appraisers License#011114

CLAIM REP PLEASE NOTE:

VEHICLE WILL NOT BE RELEASED UNTIL DTP ACCEPTANCE IS RECEIVED BY THIS SHOP

Please provide proof of DTP acceptance, in writing, by one of the following:

E-MAIL: Send Claim #, Insured's Name and "DTP accepted" to info@autoserviceandtire.com

FAX: Send Claim #, Insured's Name and "DTP accepted" to (617) 298-0226 Attn: Ward

Customer Name

Date