275 W 75th Place.
Hialeah, FL 33014
TAX ID: 45-3955746

PH: 305-364-3676
FAX: 305-364-3685

DIRECTION TO PAY

The undersigned hereby authorizes you to pay the sum of $_______ mentioned in your release of all claims for damages arising out of the above captioned collision directly to Pro Collision Center.

____________________ (SIGNATURE)

____________________ (DATE)

Insurance Company: ____________________

Insured/ Claimant: ______________________________

CLAIM #: ______________________________

Notes:

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