ATTN CLAIM REP: _____

FAX NUMBER: _____

FROM: _____@ ***Roche Collision*** Inc
TEL: ***617-969-3910***
FAX: ***617-969-3912***

DIRECTION TO PAY

I authorize the insurance company to send payments for repairs directly to Roche Collision Inc.
I also acknowledge that this form is required for the release of my vehicle if this claim has not been paid in its entirety upon completion of repairs.

_____ _____
Signature Policyholder or Claimant Date

CLAIM INFORMATION & SHOP INFORMATION:

INS COMPANY: _____

INSURED/CLAIMANT: _____

CLAIM #: _____

DATE OF LOSS: _____

Mass RS# *5102* *EXP. DATE 5/31/2023*
Tax ID# *843-052-996*
Hazardous Waste# *MV 6179693910*
Liability Insurance# *680-0P096899*
Mass Appraisers License# *013825*

SEND PAYMENT TO:

ROCHE COLLISION INC
64 CRAFTS STREET
NEWTON, MA 02458