

ADVOCATES PROFESSIONAL SERVICES, INC.  
119 No. Park Ave., Suite 303, Rockville Centre, NY 11570  
(516) 594-8400 Fax: (516) 594-4519

REFERRAL DATE: \_\_\_\_\_

**CLAIM CHECK LIST**

CREDITOR NAME: \_\_\_\_\_ CONTACT: \_\_\_\_\_

DEBTOR NAME & d/b/a: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ FAX: \_\_\_\_\_ PAGER/CELLULAR: \_\_\_\_\_

OTHER #(Home etc.): \_\_\_\_\_

CONTACT NAME/TITLE: \_\_\_\_\_

YOUR FILE/MATTER #: \_\_\_\_\_ OTHER IDENTIFYING INFO: \_\_\_\_\_

OTHER DEBTOR INFORMATION: \_\_\_\_\_

PRINCIPAL AMOUNT DUE: \$ \_\_\_\_\_ First Invoice Date: \_\_\_\_\_

Retainer: \$ \_\_\_\_\_ Last Invoice Date: \_\_\_\_\_ Last Payment Date: \_\_\_\_\_

**ENCLOSURES:**

Retention Letter: YES: \_\_\_ NO: \_\_\_ COMMENTS: \_\_\_\_\_

Detailed Billing Record: YES: \_\_\_ NO: \_\_\_ COMMENTS: \_\_\_\_\_

Correspondence: YES: \_\_\_ NO: \_\_\_ COMMENTS: \_\_\_\_\_

Payment History (Computer Printout): YES: \_\_\_ NO: \_\_\_ COMMENTS: \_\_\_\_\_

Full Name of Billing Professional:(Write in): \_\_\_\_\_

Billing Prof. Still W/Firm: YES: \_\_\_ NO: \_\_\_ May we contact Prof.: YES: \_\_\_ NO: \_\_\_ If Yes Tel. #: \_\_\_\_\_

If not w/Firm: New Firm, Address & Phone: \_\_\_\_\_

If Debtor is Commercial Entity is there also Personal Liability: YES: \_\_\_ NO: \_\_\_ COMMENTS: \_\_\_\_\_

If Yes are there documents establishing same attached: YES: \_\_\_ NO: \_\_\_ COMMENTS: \_\_\_\_\_

ADDITIONAL INFO./COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_