ATTN CLAIM REP: _____ **FROM:** **Pablo**
FAX NUMBER: _____ **Hynes Collision**
Tel: (978) 667-8697
DATE: **Fax: (978) 663-0648**

DIRECTION TO PAY

I authorize the insurance company to send payments for repairs directly to Hynes Collision Center of Billerica

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

X_____ *Date* _____
Signature of Vehicle Owner

CLAIM INFORMATION:

Company: _____
Vehicle Owner: _____
Type of Loss: _____
Claim#: _____
Date of Loss: _____

SHOP INFORMATION:
Send Payment To:

Hynes Collision Center
6 Hadley St.
N. Billerica, MA.01862

Mass RS# 100351 Exp. 05/31/2028
Tax ID# 39-3975209
Hazardous Waste# MV9786678697
Mass Appraisers License# 17508446
Liability Ins. # S 2675221

Attention Claim Representative

THIS VEHICLE WILL NOT BE RELEASED UNTIL DTP ACCEPTANCE IS RECEIVED BY 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 Pablo@Hynescollision.com
PC Fax: Send Claim #, Insured's Name and "DTP accepted" to (978) 663-0648 Attn: Pablo
Fax: Sign below and fax this form to (978) 663-0648 Attn: Pablo

X_____ Date: _____
Claim Rep Signature