AutoFax Transmission Request Form

Date: _____

Dr. _____

6 Digit Billing # _____

Fax # _____

Fax Times: Choose (1) ONLY:

6:00 am
9:00 am
11:00 am
2:00 pm
4:30 pm

CONTACT PERSON _____

TELEPHONE # _____ _____

OFFICE USE ONLY:

LOC: _____

DOC. ALPHA: _____

Autofax Started: _____

Hard Copies Stopped: _____

Change of Fax Times – Date: _____

From / To _____ / _____

Verification of Receipt of Faxes

Contact person: _____

Date: _____

C/S Personnel Initials: _____