

## APPEALS CLAIM FORM

You must submit this claim form to CareCredit at **PO Box 628407 Orlando, FL 32862-8407** within ninety days of receiving your notice from CareCredit for your claim to be considered.

This Claim Form will be kept confidential and will be used only for purposes of: (1) confirming that you are eligible to file a claim under CareCredit's agreement with the Consumer Financial Protection Bureau; and (2) evaluating the basis for your specific claim.

### SECTION A – CLAIMANT INFORMATION

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Apt. No., if applicable

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
CareCredit Account  
Number

### SECTION B –DISPUTED CHARGE INFORMATION(S)

Date of disputed transaction: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MM DD YY

Amount in dispute: \$\_\_\_\_\_

Healthcare providers name: \_\_\_\_\_

