Bishop's body shop since 1971

Direction of Payment

Vehicle Owner's Name: _____

Vehicle Description: _____
Year Make Model VIN

Insurance Company: _____ Date of Loss: _____

Claim Number: _____ Amount: _____

I have received a copy of the initial and final repair estimate.
I authorize _____ to pay Bishop's Body Shop on my behalf.

_____ _____
Vehicle Owner's Signature Date

_____

I certify that repairs have been completed as indicated on the final repair estimate.

_____ _____
Repairer's Signature Date

This form must be retained in repairer's records for at least 6 months, or longer if required by state law.

NOTE: For your protection, the law of your state requires the following to appear on this form: Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a felony and subject to criminal and civil penalties. Violation of this provision is a felony of the third degree.

BISHOP'S BODY SHOP
COMPLETE COLLISION REPAIR
1111 W. Canal Street, New Smyrna Beach, FL 32168
PHONE (386) 427-3538 FAX (386) 427-1116