



CUSTOMER CARE SYSTEM  
CLAIM FORM

Claim Number

Must be displayed on all correspondence

MCI FLEET SUPPORT

MCI Fleet Support Fax: 1-800-360-8886

U.S.A.	CANADA
<i>In instances where MCI requires defective parts to be returned, please ship to:</i> <b>MCI FLEET SUPPORT</b> 7001 Universal Coach Drive Dock 24 Louisville, Kentucky 40258	<i>In instances where MCI requires defective parts to be returned, please ship to:</i> <b>MCI FLEET SUPPORT</b> 260 Toronto Street New Castle, Ontario L1B 1C2

CCS Account Number : \_\_\_\_\_ Vehicle Id Number: \_\_\_\_\_

Company Name: \_\_\_\_\_ Mileage: \_\_\_\_\_

Street Address: \_\_\_\_\_ Fleet Number: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Date Failed: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Repair Order #: \_\_\_\_\_

Fax Number : \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

MCI Causal Part # : \_\_\_\_\_

\_\_\_\_\_ Yes, I would like to subscribe to MCI's monthly e-mail newsletter, "FYI from MCI". My preferred e-mail format is:

HTML \_\_\_\_\_ PDF Link \_\_\_\_\_ Text \_\_\_\_\_

COMPLAINT : \_\_\_\_\_

\_\_\_\_\_ No, thanks. I would not like to subscribe at this time.

CAUSE : \_\_\_\_\_

CORRECTIVE ACTION: \_\_\_\_\_

IF REPAIRS WERE SUBLET, A COPY OF THE INVOICE MUST BE SUBMITTED

QTY	MCI PART #	PART DESCRIPTION	PART COST Blank if MCI Supplied	LABOR HOURS
			Part Total	Labor Total

NOTE: ALL INFORMATION REQUESTED ABOVE MUST BE FILLED IN OR CLAIM CANNOT BE PROCESSED.

Claim Total

Signature: \_\_\_\_\_ Date Submitted: \_\_\_\_\_