



| For CMS Office Use Only: | |
|--------------------------|------------------|
| Date CMS Received: _____ | DDA: _____ |
| Date Change Made: _____ | By: _____ |
| Date Scanned: _____ | Sent NCal: _____ |

Merchant Account Closure Request Form

Merchant Name: _____

Merchant Number: _____

Reason for Closing Account:

Note: Reason must be stated in order for account to be properly closed. Thank you.

Signature of Authorized Principal
(as specified on the Merchant Application/Agreement)

Date

Printed Name

Phone

Email Address

Please fax this request form to our customer service team at: 1-888-353-3040.

Please contact our customer service department at: 877-267-4324 or at customersupport@cmsonline.com with any questions.