

CREDIT/DEBIT CARD TRANSACTION AUTHORIZATION

CUSTOMER/ACCOUNT NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE (HOME): _____ (WORK): _____

CREDIT/DEBIT CARD INFORMATION

CARDHOLDER'S NAME: _____

CARD BILLING ADDRESS: _____

CARD BILLING ZIP CODE: _____ CARDHOLDER'S PHONE #: _____

CARD NUMBER: _____

CARD TYPE (CIRCLE): VISA M/C AMEX EXPR DATE: _____

CVV2#: _____
(Last three (3) #'s on white stripe on back of card after card #, or four (4) #'s on left front of AMEX Card.)

AUTHORIZATION

I, (print name) _____
DO HEREBY AUTHORIZE CARE ACCESS HEALTH PLAN, INC. TO CHARGE \$ _____
TO THE ABOVE NOTED CREDIT/DEBIT CARD FOR GOODS AND/OR SERVICES RENDERED.
SIGNATURE: _____ DATED: _____

<p>PLACE YOUR CREDIT/DEBIT CARD UNDER THE PAPER AND INSIDE THE BOX TO THE RIGHT. RUB THE RAISED LETTERS AND NUMBERS WITH THE SIDE OF A PENCIL SO THAT THE CARDHOLDER'S NAME, THE CARD'S NUMBER AND THE EXPIRATION DATE CAN BE READ ON THE FRONT OF THIS AUTHORIZAITON FORM. MUST BE READABLE IN THE BOX!</p>	
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