CREDIT CARD PAYMENT AUTHORIZATION

PLEASE RETURN TO: 8300 Bissonnet St Suite 120 Houston, TX 77074
Phone: (713) 981 7700 Fax: (713) 981 7719 E-Mail: je@anvicare.com

Practice Name / Billing Service				
Provider ID #:				
Address:	Street	City	State	Zip
Phone	Fax	E-Mail		
Authorized Contact Person		Title		
Authorized Contact Signature **X**		Date		

CREDIT CARD CHARGE AUTHORIZATION

Provide expiration date

? MASTERCARD **?** VISA
ACCOUNT NUMBER

																EXPIRATION DATE

VERIFICATION NUMBER (3 digit on the back of card)

CARDHOLDER'S BILLING ADDRESS – (If different from above)

PLEASE SIGN

CARDHOLDER'S SIGNATURE

X

CARDHOLDER'S NAME (PRINT)

Please complete the information and return this form **by mail**. We require a signature and your credit card authorization to be on file with AnviCare, Inc. For immediate purposes you may fax it.