PharmcareOK, PharmcareUSA, Pharmacy Care, Advanced Pharmacy
Corporate Offices, PO Box 70, 510 Arapaho, Hydro, OK 73048 Ph: 866-403-2003 Fax: 405-663-4114

ONE TIME PAYMENT ENROLLMENT FORM

Please PRINT CLEARLY in blue or black ink.

PATIENT ACCOUNT INFORMATION

LAST NAME : _____ FIRST NAME: _____ MI: _____

PHARMACY LOCATION OR FACILITY NAME: _____

DAYTIME TELEPHONE NUMBER: _____ CELL PHONE NUMBER: _____

PHARMACY ACCOUNT # :1) _____ 2) _____

OPTION 1: ONE TIME BANK DRAFT — PLEASE COMPLETE THE FOLLOWING SECTION

*****PLEASE ATTACH VOIDED CHECK FOR BANK DRAFT*****

TYPE OF ACCOUNT: CHECKING □ SAVINGS □ OTHER □

ACCOUNT #: _____ ROUTING#: _____

BANK NAME: _____

NAME AS IT APPEARS ON ACCOUNT: _____ RELATIONSHIP TO PATIENT: _____

ACCOUNT ADDRESS: _____ APT /P.O. BOX: _____

CITY: _____ STATE: _____ ZIP: _____

OPTION 2: ONE TIME CREDIT CARD CHARGE — PLEASE COMPLETE THE FOLLOWING SECTION

TYPE OF CARD: VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS ☐

CREDIT CARD NUMBER #: _____

EXPIRATION DATE: _____ CVV2 CODE: _____

NAME AS IT APPEARS ON CARD: _____ RELATIONSHIP TO PATIENT: _____

BILLING ADDRESS: _____ APT /P.O. BOX: _____

CITY: _____ STATE: _____ ZIP: _____

AUTHORIZATION

By my signature below, I authorize PharmcareUSA or its subsidiaries to charge the above listed checking, savings, or credit card account for all fees or other charges owing to PharmcareUSA or its subsidiaries.

*****PLEASE ATTACH VOIDED CHECK FOR ONE TIME BANK DRAFT*****

SIGNATURE: _____ DATE: _____

DAYTIME PHONE: _____ _____ RELATIONSHIP TO PATIENT: _____