PharmcareOK, PharmcareUSA, Pharmacy Care, Advanced Pharmacy
Corporate Offices, PO Box 70, 510 Arapaho, Hydro, OK 73048 Ph: 866-219-3619 Fax: 405-663-4114

AUTOMATED PRESCRIPTION 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: MONTHLY BANK DRAFT — PLEASE COMPLETE THE FOLLOWING SECTION

PLEASE ATTACH VOIDED CHECK FOR MONTHLY 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: MONTHLY 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. This agreement will remain in effect until the cardholder revokes authorization in writing.

PLEASE ATTACH VOIDED CHECK FOR MONTHLY BANK DRAFT

SIGNATURE: _____ DATE: _____

DAYTIME PHONE: _____ _____ RELATIONSHIP TO PATIENT: _____