

**CREDIT CARD AUTHORIZATION FORM**

**First Time Authorization**:\_\_\_\_\_\_ **Update Information**:\_\_\_\_\_\_\_\_\_

CMMC Pharmacy accepts MasterCard and Visa (including debit cards and/or health plan benefit “benny” cards which have the MasterCard or Visa designation)(“Credit Card”) for the payment of fees incurred at CMMC Pharmacy. By signing this form, I understand and agree that I am the cardholder of the Credit Card described below, and that I am authorizing **all** charges (including one-time charges, recurring charges, and charges for prescriptions, OTC items and retail items) for the persons listed below to be applied to my Credit Card.

**Name of Person Authorizing Payment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID/Kronos D:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits of SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize **all** charges incurred by the following persons at CMMC Pharmacy to be charged to the Credit Card described in Section 2 below (please list first and last names and relationship to cardholder)(“Authorized Person(s)”):

Name of Authorized Person/Relationship to Cardholder Name of Authorized Person/Relationship to Cardholder

A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Credit Card Account Information**:

Cardholder Name (exactly as it appears on the Credit Card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Three Digit VID on back:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle One: MasterCard Visa AMEX Discover Circle one (if applicable): Debit Card Benny Card

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder’s Daytime Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CMMC Pharmacy sends notice via email or text message when prescriptions are ready to be picked up. I understand that no other notification will be provided to me prior to CMMC Pharmacy initiating charges for prescriptions, and no prior notification will be provided to me for non-prescription charges made to my Credit Card by Authorized Persons. I understand that it is my responsibility to contact CMMC Pharmacy if I need additional detailed information regarding amounts that will be charged to my Credit Card under this Authorization.

I will ensure that charges authorized by this form shall not cause my Credit Card account to exceed any established credit limits (for credit cards) or account balances (for debit cards or benny cards) as of the date of the charge. I further authorize CMMC Pharmacy to initiate a charge or credit as necessary to correct any prior overpayment or underpayment of any charge or credit performed under this Authorization. I agree that I will not dispute payment to CMMC Pharmacy with my credit card company so long as the transaction corresponds to the terms indicated in this Authorization form.

This Authorization will remain in effect until written notice of termination or update is given to CMMC Pharmacy. I understand I am responsible for informing CMMC Pharmacy of any changes in the above information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Employee signature)

**PLEASE MAIL OR FAX COMPLETED FORM TO CMMC PHARMACY,**

**300 Main Street, Lewiston, ME 04240**

**Fax # 207.795.7552**