



DEBIT CARD TRANSACTION AUTHORIZATION

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

DEBIT CARD INFORMATION

CARDHOLDER'S NAME:
DC BILLING ADDRESS:
DC BILLING ZIP CODE: CARDHOLDER'S PHONE #:
DEBIT CARD NUMBER:
CARD TYPE (CIRCLE): VISA M/C AMEX EXPR DATE:

CVV2#:
(Last three (3) #'s on white stripe on back of card after credit 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 DEBIT CARD FOR GOODS AND/OR SERVICES RENDERED.
SIGNATURE: DATED:

PLACE YOUR 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!