RACHAP Patient Payment Information

Account #: ______________________ Date: ______________________

Contact Name: ______________________

Veteran's Name: ______________________ Last 4 SS#: ______________________

Payment Information:

I authorize up to $ __________ for the purchase/service of ______________________ hearing instrument(s) and __________ remote control/adapter to be charged to my: MasterCard Visa American Express
(please circle one)

Credit Card #: ______________________ Exp Date: __________ Security Code: __________

Cardholder's Name: ______________________ Cardholder's Phone #: ______________________

Cardholder's Address: ______________________

____

Signature: ______________________ Date: ______________________

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