



**Credit Card Authorization Form –
Fax completed form back to 1-866-583-6093**

This form authorizes MedicaitonCard.net LLC to use my credit card information provided below for the purpose of ordering additional Medication Cards for my Medication Card affiliate account:

Your GRP #: _____ Agent Name: _____

Number of cards requested to be ordered: _____

Billing Contact Info (as it appears on your credit card statement):

Name (as it appears on credit card: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Circle Credit Card Type: Visa MasterCard Discover American Express

Credit Card: _____

Expiration Month/Year: _____ 3-Digit CSV Code on Back: _____

I authorize MedicationCard.net LLC to use the above credit card information as payment for the additional Medication Cards that I have requested to be ordered.

Agent Signature

Agent Printed Name

Date of Authorization