

MAIN LINE HEALTH EMPLOYEE PHARMACY

Patient Accounting – Payment Processing

CREDIT CARD PAYMENT FORM

Employee Name: _____

General Account#: 10000 58275 02126

Amount of Payment: \$ _____.

Card Holder Name: _____

Credit Card Number: _____

Card Expiration Date: ____/____

Type of Card: ____ Visa ____ Mastercard ____ American Express __ Discover

Customer Address: _____

City _____ **State:** _____ **Zip Code:** _____

Customer Home Telephone Number: _____

Customer Work Telephone: _____

Card Holder Signature: _____

Date: _____

Received by: _____