



**CareFirst Specialty Pharmacy**  
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**Credit Card Authorization Form**

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**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Company Name: (if applicable)** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

This approval form must be **signed by the cardholder** (who is the Cardholder/Owner/Officer/Partner in the company) authorizing CareFirst Specialty Pharmacy to debit the specified credit card.

**Cardholder Name:**

(Name as shown on card; PLEASE PRINT) \_\_\_\_\_

**Card Type**

American Express

MasterCard

Visa

Discover Card

**Credit Card #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Card BILLING Address:**

(FULL billing address where credit card statement is sent) Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**Expiry Date:** \_\_\_\_\_

**Verification Code:** \_\_\_\_\_

(the last three digits of the number located in the signature line on the back of the credit card for Visa, MC, Discover. 4 digits on front of American Express)

CareFirst Specialty Pharmacy is hereby authorized to accept orders from individual/business indicated above, charge the cost this/these order(s) to the above credit card account and ship the merchandise as requested. By signing this document, I/we accept full responsibility for these transactions and ensure full payment to CareFirst Specialty Pharmacy. I will inform CareFirst Specialty Pharmacy immediately if use of the card is no longer authorized.

**I hereby authorize CareFirst Specialty Pharmacy to use this credit card account until further notice:**

**Signature:** \_\_\_\_\_