



**CareFirst Specialty Pharmacy**  
 400 Fellowship Road, Suite 100, Mount Laure, NJ 08054  
 Office: 856-267-0528 / Toll-Free: 844-822-7379  
 Fax: 856-267-0529 / Toll-Free: 844-922-7379  
 Email: csr@cfspharmacy.com  
 www.cfspharmacy.pharmacy

**Credit Card Authorization Form**

This fax is privileged and/or confidential, and the sender does not waive any related right and obligations. Any distribution, use or copying of this fax or the information it contains by other than an intended recipient is unauthorized. If you receive this fax in error, please advise the sender immediately.

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