



Confidential

Fax: 800.541.5967

Credit Card Payment Request Form

This form is to be treated as confidential when filled out.

Date of Request _____/_____/_____ Account # _____

Company Name _____

City/State _____

Name on Credit Card _____

Address Credit Card Bill Is Being Sent To _____
(Address) (Zip Code + 4)

Contact Name _____

Contact Phone Number () _____

E-mail Address (optional) _____ (for automatic notification of charges)

Credit Card Type (16 Digits)  

Credit Card Number _____

Expiration Date _____/_____
(Month) (Year)

Invoice Numbers _____

or _____

Order Numbers _____

Check One This Time Only Always When Requested

The authorized cardholder's signature shows agreement with this company to process the above invoice(s)/order(s) for payment, as per the credit card payment terms. This agreement is good until the credit card expires or until notification is made.

Authorized Cardholder's Signature _____