PRESCRIPTION
PHARMACY SERVICES

Enrollment and Credit Card Authorization Form

CAMPER INFORMATION

Name DOB

Allergies

CREDIT CARD INFORMATION

YOUR CREDIT CARD INFORMATION WILL BE STORED IN OUR SECURE PHARMACY SYSTEM.

☐ I prefer to provide my credit card information over the phone.
PPS will call you to retrieve your credit card information upon receipt of your form.

Type ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover/Novus

☐ Other, please specify:

Card Number

Cardholder Name

Credit CVC number (3 Digit Number on Reverse of Card) Expiration Date

BILLING ADDRESS

Street City

State Zip Code Country Save CC to file? ☐ Yes ☐ No

Phone number: Work number:

I hereby authorize Prescription Pharmacy Services, LLC to bill my credit card account on a once monthly basis for products and services provided. Applicant agrees that all information provided is accurate and complete.

Signature:_____ Date: _____

SEND FORM TO PRESCRIPTION PHARMACY SERVICES

1. Mail: Prescription Pharmacy Services, 285 Governor St., Lower Level, Providence, RI 02906
2. Fax: 1-855-439-4579

*****PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD*****