Charge Authorization Form

Customer Name: _____ **Location:** _____

CustID: _____ **Location Address:** _____

Location City, State & Zip: _____

I authorize Lincare to debit my account indicated below for amounts not
(Lincare Company Entity)
covered by my respective insurance coverage. I also authorize my depository financial institution to honor these transfers.
This is an open authorization to allow debits to my account for amounts not covered by my insurance. I understand that such amounts may vary based on the services provided to me and my insurance coverage, but will not exceed $5,000 in any given month.
This authorization is for a Single-Entry charge or Recurring charges for services provided and billable.
I acknowledge I will receive notice of the actual amount to be billed before the debit.

I certify that I am the authorized account holder for this account. This agreement will remain in effect until
Lincare receives my written notice of cancellation via mail.
(Lincare Company Entity)

_____ _____
Authorized Accountholder Signature (required) **Date (required)**

Accountholder Name (Please Print): _____ Recurring ID: N/A

Accountholder Address: _____

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

Select one of the following payment options:

☐ **Credit/Debit Card- Enter the last four digits of your Account #, expiration date**

Visa®	4******** _____	Exp. Date: ____ / ____
MasterCard®	5******** _____	Exp. Date: ____ / ____
American Express®	3******** _____	Exp. Date: ____ / ____
Discover Card®	6******** _____	Exp. Date: ____ / ____

☐ **Check Draft- Select the type of account and complete the banking information**

☐ Checking Account ☐ Savings Account

Bank Name: _____ Branch: _____

Routing Number: _____ Last four digits of account #: _____

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If you should have any questions in regards to the amount charged or need to notify us of your intent to cancel and/or revoke this authorization, please contact the billing office listed on your Customer Statement.