



## CREDIT CARD AUTHORIZATION FORM

Dear Valued Customer:

If you are interested in using your credit card (VISA or Mastercard only) as payment on your account, please complete the following information and return to us via fax, email, or mail. Please TYPE all information as illegible information may be returned if handwritten.

All information including signature is REQUIRED.

- One-time authorization – if you choose this option, it will be a one-time authorization only and this information will NOT be retained for future invoices.
- Automatic authorization – invoices are mailed out on the first business day of each month. Should you choose this option, you will still receive an invoice, but your credit card will not be billed until the fifth business day of the month. If there are any changes to your card or you simply wish to use a new credit card, you must complete an additional form.

There are no transaction or processing fees for paying via credit card.

Company/Office/Provider Name: \_\_\_\_\_

Date Form Submitted: \_\_\_\_\_

Name exactly as it appears on card: \_\_\_\_\_

Billing address for credit card (this must include street address or PO Box as well as city, state and zip code): \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Submitted By: \_\_\_\_\_

Signature of cardholder (this must be of the cardholder only):  
\_\_\_\_\_

Please circle: VISA OR MASTERCARD

Please circle: ONE-TIME PAYMENT OR AUTO-PAYMENT

CREDIT CARD #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp Date: \_\_\_\_/\_\_\_\_  
CVV/Security Code: \_\_\_\_\_

\*Fax this form to: 812-759-1524 attn: Accounting Department

\*Mail this form to: Quantum Health Automation, Attn: Accounting Dept. 201 NW 4<sup>th</sup>, #103, Evansville, IN 47708

\*Email this form to: [qha@qhaclaims.com](mailto:qha@qhaclaims.com)

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INTERNAL USE ONLY:

Client id: \_\_\_\_\_ Approved by: \_\_\_\_\_ Date: \_\_\_\_\_