RED RIVER Rx
LONG-TERM CARE

CREDIT CARD AUTHORIZATION FORM

Customer Number:
Patient Name:
Account Holder Name:
Billing Address: _____
Card Type: Visa: ☐ Discover: ☐ MasterCard: ☐ Amex: ☐ Other: _____
Credit Card Number:
Expiration Date:
CVV Code (Security Code on Back of Card):
Signature:

I want Red River Pharmacy to draft payment for my account balance: _____

I want a set monthly payment of: _____

PLEASE COMPLETE FORM AND RETURN BY FAX TO 844-308-7975, EMAIL TO ltcbilling@redriverrx.com, or MAIL TO RED RIVER PHARMACY at 1550 MOORES LANE TEXARKANA, TX 75503

By signing this form, cardholder agrees to let Red River Pharmacy process payment with the above information for the entire account balance, each month, unless otherwise notated on this form.