



Credit Card Authorization Form

In order to better service our customers we now accept credit card payments from Visa, MasterCard and American Express. If you wish to charge your invoice by credit card please fill out the following form. We also continue to accept payments by check. Checks should be mailed to:

PL Medical Co., LLC
321 Ellis Street
New Britain, CT 06051

Please remember to include your invoice number on your check.

Credit Card Information																			
<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express																	
Name																			
Billing Address																			
Billing City, State, Zip																			
Daytime Phone Number																			
Daytime Fax Number <small>(a receipt will be faxes to this number)</small>																			
Credit Card Number																			
CID (Card ID #)									Last 3 digit numbers on the back of your card or 4 digit number on the front of Amex										
Expiration Date (mm/yy-yy)							/												

I authorize PL Medical Co., LLC to bill my credit card per the instructions below:

Bill my credit card once for the following amount:	\$																		
Please apply this payment to the following Invoice:																			

All information provided is accurate and complete. Disputes to amounts invoiced should immediately be reported to orders@plmedical.com or (800) 874-0120.

The undersigned is the duly authorized representative for the above credit card.

Authorized Signature: _____ **Date:** _____

Please fax the completed form to PL Medical Co., LLC at
(860) 223-5941.

Upon processing a receipt will be faxed to the number indicated on the sheet.