MED4HOME®

Automatic Billing Authorization Form

Customer Name: _____

CustID: _____ **Start Date:**_____ **Location:** 90-40-36-11

I authorize Med4Home Inc. to initiate funds from the account indicated below. 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 respective insurance coverage.

I certify that I am the authorized account holder for this account. This agreement will remain in effect until Med4Home receives my written notice of cancellation via mail, fax, or email.

_____ _____

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

Accountholder Name (Please Print): _____ **Recurring ID:** _____

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 #: _____

2001 NE. 46th St. Ste 150 Kansas City, MO 64116
Phone 888-792-4456 Fax 816-801-7311