ReSound
GOVERNMENT SERVICES

Retiree's At Cost Hearing Aid Program (RACHAP)

Credit Card Authorization

Account Information

Account Number:________________________

Account Name:__________________________

Account Phone #:________________________

Account Contact:________________________

Patient Name:___________________________

____

Billing Information

Billing Address:__________________________

____

City:_________________State:__________

Zip Code:____________

Credit Card Information & Authorization

Amount Charged not to exceed:$__________

Name on Card: ___________________________

____

Credit Card Type:

☐ Visa ☐ MC ☐ Discover ☐ AmEx

Credit Card #: ___________________________

3 or 4 digit number on back of card: ____________

Expiration Date:___________________________

I authorize the above charge to my credit card for hearing aids.

Signature:_________________________________

Date:___________________

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