Medi-Mart Pharmacy

SOMERSET
SPECIALTY & LTC PHARMACY

AAP
AMERICAN ASSOCIATED PHARMACIES

PAYMENT OF ACCOUNTS

To ensure your account is kept current we are requesting credit/debit card information to be used for charges incurred at Medi-Mart Pharmacy. You will receive a monthly statement of medications and supplies along with the charge/debit card receipt in the mail. If you have any questions, please contact us. All information is kept strictly confidential. Please print all information.

Patient Name _____

Card Type ☐ VISA ☐ MASTER CARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Card Number _____

Exp. Date _____ CVV Code _____

Name on Card _____

Billing Address _____

City _____ State _____ Zip _____ Phone _____

I hereby give authorization to Medi-Mart Pharmacy to charge/credit the above credit/debit card for charges incurred on a monthly basis.

Signature _____ Date _____

FOX HILLS: (248) 858-2225
SOMERSET: (248) 237-4455

www.somersetmedimartpharmacy.com