

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> JCB <input type="checkbox"/> AMEX <input type="checkbox"/> Diners Club <input type="checkbox"/> UnionPay
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I, _____ authorize Value Care Health Systems, Inc. to charge my credit card above for agreed membership fee and other charges.

I understand that my information will be saved to file for future transactions on my account.

I have read, understand and duly signed the Data Sharing Agreement attached to this Authorization Form.

Member Signature

Date

VALUE CARE HEALTH SYSTEMS, INC.

Value Care Building, 33 Meralco Avenue, Barangay San Antonio, Pasig City
 Trunk lines: (02) 702-3310 (Medical Services); (02) 702-3388 / 317-4388 (Other Departments)
 24 Hour Hotlines: 0917-7-WECARE / (02) 687-3219 / 317-4310 / 0917-8862892 / 0925-6100301
 Fax no: (02) 637-9456 Email: wecare@valuecarehealth.com