FlagshipHealth | Group™

612-209-6002 23505 Smithtown Road, Suite 200, Excelsior, MN 55331

# Account Information Payment Authorization Form

## Customer/Clinic Information

Customer/Clinic Name

Street Address

Suite/Other

City | State | Zip Code

Email Address

Phone Number | Fax Number

## Provider/Physician Name

First Name | Last Name

CLIA Certification Number(if applicable)

Physician/Provider NPI

## Key Contact

First and Last Name

Email Address

Phone Number

## Credit Card Administrative Information

First Name As Appears On Card

Last Name As Appears On Card

Billing Address

City | State | Zip Code

Email Address

## Credit Card Authorization Information

Credit Card Number

Exp Date Mo/Yr (xx/xx) | CCV Code

VISA ☐ MasterCard ☐ AMEX ☐ DISCOVER ☐

Authorized Signature

## ACH Administrative Information

First Name As Appears On Account

Last Name As Appears on Account

Billing Address

City | State | Zip Code

Email

## ACH Banking Authorization Information

Bank Name

ABA Routing Number

Account Number

**Bank Account Type**

- ☐ Business Checking
- ☐ Personal Checking
- ☐ Savings Account

Authorized Signature

**Please submit completed form to:**
**customerservice@fssrx.com**

- ☐ Distributor
- ✔ Sales Executive

Rollin Lacy
Name

rlacy@fssrx.com
Email