Teamsters Rx Pharmacy
PO Box 5242
Manchester NH 03108
Telephone 866-888-0104
Fax: 603-413-6410

CREDIT / DEBIT CARD AUTHORIZATION FOR PHARMACY MAIL-IN CO-PAYMENTS

Local _____ Teamsters Rx Id # _____

Last Name **First Name**

Name On Card

Your Billing Address

City

State Zip Code – Your Telephone – –

Card Number Expiration Date Month Year –

Type Of Card

☐ MasterCard ☐ Debit Card* *Debit Card must bear a major Credit Card Logo

☐ Visa ☐ Discover/Novus

Family members authorized to have co-pays charge to this Credit Card

1

2

3

4

5

6

Card Holder Signature _____ Signature _____ Date