The Mount Sinai Hospital
One Gustave L. Levy Place
New York City, N.Y. 10029-

Mount Sinai Credit Card Authorization

Credit Card Amount Due: **$**________________________

Type of Card to be Charged: ☐ VISA ☐ MasterCard ☐ American Express

Card number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration date: Month ☐☐ Year ☐☐

Cardholder Name ____________________ Cardholder statement billing address ____________________

Patient Last Name ____________________ Patient First Name ____________________

☐ InPatient ☐ Out Patient ☐ Maternity

Service date ____/____/____

Patient Account Number________________________ Stay number/Reg.________________________

Bill Reference Number__________________________

Account Representative____ Date_______________

Approval Signature____ Date_______________

Authorization:

The Signer below agrees to pay the total amount specified above in accordance to the card issuer agreement (Merchant agreement if Credit voucher)

Cardholder Authorization____ Date_______________

Revised on 4/25/2006