

HME SOLUTION

Registration for HME STORE Program

Pharmacy Name _____ Phone Number _____
Location Address _____ City/State/Zip _____
Mailing Address (if different) _____
E-mail Address _____
Preferred Contact Name _____

Credit Card Information:

Card Holder Name: _____ Card Number _____
Card Type _____ Expiration Date _____ Security Number _____
Billing
Address _____

Approval Signature _____

I understand that my credit card will be charged \$200.00 (U.S. Value) per month. This monthly charge can be terminated by written instruction to HME Solution to do so.

Authorization Signature _____