CREDIT CARD PAYMENT FORM

Please complete and return this form **by fax** to +41 41 379 0398 or **by post**. For your security; if you wish to send it by email please write to contact@ovag.ch and we will send you a **secure email** for you to respond.

Provider / OVAG reference: _____

Patient name: _____

Amount to charge: **USD** _____

In order to pay an amount in another currency contact us. Amounts are charged in the currency of the provider.

Cardholder name: _____ *(as it appears on the card)*

Type of card: MasterCard ☐ Visa ☐ Amex ☐ Discover ☐ Other: _____

Credit card number: _____

Expiry date: _____ **CVV security code:** _____ *(3 or 4 digits, see footer)*

Address where card is registered: _____

Street

_____

City **Postal code** **State/Province/Region** **Country**

I hereby authorise the provider or OVAG International to debit the amount given above from my credit card. I also hereby confirm that I am authorised to use this credit card and will not dispute the charge.

Date: _____ **Cardholder's Signature:** _____

Email / Mail receipt to: _____

Contact phone number: _____

MasterCard, Visa and Discover – 16-digit card number & 3-digit CVV on back of card
Amex – 15-digit card number & 4-digit CVV on the front of the card